Commission on the Future of Health Care in Canada

CANADA

Commission sur l'avenir des soins de santé au Canada

SHAPE THE FUTURE OF HEALTH CARE

ROY J. ROMANOW, Q.C.

COMMISSIONER

COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA

Interim Report • February 2002

The Following Principles Will Guide the Commission's Activities and Operations

Objective: The Commission will accept and review on its merits any proposal or recommendation to strengthen the quality, effectiveness and continued viability of Canada's health care system and to place it on a sustainable footing.

Open and Transparent: The Commission will operate in an open and transparent manner by making publicly available in a timely way: any research it undertakes or commissions; any submissions it receives, whether or not these have been formally solicited; and, any relevant advice, reports or correspondence to or from federal, provincial and territorial and Aboriginal officials or representatives.

Comprehensive: Prior to issuing recommendations on any subject, the Commission will consider alternative perspectives and will demonstrate that its research methodology is sound and objective.

Evidence-based: The Commission will gather, synthesize, assess and reference any available evidence it is aware of that supports its findings, conclusions or recommendations.

Inclusive: The Commission will make every reasonable effort to facilitate broad public, stakeholder and expert access to and participation in its activities, consultations and deliberations.

Respectful: Whenever possible, reasonable and appropriate, the Commission will: take account of existing knowledge; avoid asking individuals or groups to submit information or views they have already made publicly available; and, minimize the risk of its activities duplicating or overlapping with ongoing (or recently completed) consultative efforts.

SHAPE THE FUTURE OF HEALTH CARE

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TO HER EXCELLENCY THE GOVERNOR IN COUNCIL

I am pleased to submit for your consideration the Interim Report of the *Commission on the Future of Health Care in Canada* created by Order in Council P.C. 2001-569.

Since having been granted the privilege of serving as Commissioner for this important national endeavour, my staff and I have worked diligently to fulfill the mandate that you have assigned in a timely, objective, comprehensive, and cost-effective manner.

As outlined in this Interim Report, our efforts have been divided into two distinct phases. The first phase, which began immediately upon my appointment, has focused on fact-finding. The second phase, which begins formally with the public release of this Interim Report, will focus on engaging Canadians in a national dialogue on the future of their health care system.

Throughout our fact-finding phase, we have consulted broadly with key health care system stakeholders, and provincial and territorial governments and Aboriginal organizations, to narrow the focus of our research and consultation priorities. In addition to gathering and synthesizing currently available information on health care in Canada and elsewhere, we have also sought to identify knowledge gaps and, where necessary and feasible, to commission new research to bridge them. Indeed, one of the important legacies of my Commission will be to advance the state of knowledge of health care in Canada.

During our consultation and dialogue phase we will work collaboratively with a variety of partners to provide concerned Canadians the opportunity to participate in informed discussion on the future of health care in Canada. Our consultation plans are outlined in this Interim Report.

That Canadians feel a profound attachment to their health care system and view it as a defining element of their citizenship is obvious. I am deeply committed to ensuring that the health care system continues to give real expression to the values Canadians share. Suffice it to say, the coming months promise to be challenging and exciting ones as we work toward completing our final report.

In closing, I would like to acknowledge the tremendous support I have received from my staff and, in particular, from my Executive Director, Gregory Marchildon. This Interim Report is testament to their diligence, professionalism, and commitment.

Respectfully submitted,

Roy Romanow

Roy J. Romanow, Q.C.
Commissioner

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P.C. 2001-569

CANADA
PRIVY COUNCIL

Certified to be a true copy of a Minute of a Meeting of the Committee of the Privy Council, approved by Her Excellency the Governor General on the 3rd of April 2001

Whereas achieving and maintaining good health and ensuring universal access to quality health services is a matter of concern to all Canadians;

Whereas in September, 2000, all First Ministers on behalf of Canadians affirmed their support for a common vision for health and for the five principles embodied in the *Canada Health Act*;

Whereas all First Ministers, in addition to agreeing on specific measures, committed themselves and their governments to a partnership to strengthen and renew health services for Canadians;

And whereas the strong attachment of Canadians to a health system that meets the needs of all Canadians and the commitment of governments to work together constitute the foundation for a public dialogue on the long-term sustainability of Canada's publicly funded health care system;

Therefore, the Committee of the Privy Council, on the on of the Prime Minister,

(*a*) advise that a Commission do issue under Part I of the *Inquiries Act* and under the Great Seal of Canada appointing Mr. Roy J. Romanow, Q.C., as Commissioner to inquire into and undertake dialogue with Canadians on the future of Canada's public health care system, and to recommend policies and measures respectful of the jurisdictions and powers in Canada required to ensure over the long term the sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment;

(*b*) direct that the Commissioner be authorized to conduct the work of the inquiry in two stages, the first focusing on fact-finding resulting in an interim report and the second emphasizing dialogue with the Canadian public and interested stakeholders based on the interim report;

P.C. 2001-569

(*c*) direct that the Commissioner submit an interim report (based on the work conducted in stage one), in both official languages, to the Governor in Council in approximately nine months, and a final report (based on the interim report and the work conducted in stage two) with recommendations, in both official languages, to the Governor in Council on or about November, 2002; and

(*d*) advise that the Commissioner

(i) be authorized to appoint advisers and create advisory mechanisms as he deems appropriate for the purpose of the inquiry,

(ii) be authorized to consult with provinces and territories and groups and individuals having an interest in or responsibility for health care in Canada and to use the means and vehicles required to ensure that a dialogue with Canadians occurs during the course of the inquiry,

(iii) be authorized to adopt such procedures and methods as he may consider expedient for the proper conduct of the inquiry, and to sit at such times and in such places in Canada as he may decide,

(iv) be authorized to rent such space and facilities as may be required for the purposes of the inquiry, in accordance with Treasury Board policies,

(v) be authorized to engage the services of experts and other persons as are referred to in section 11 of the *Inquiries Act*, at such rates of remuneration and reimbursement as may be approved by the Treasury Board,

(vi) be directed, in making his interim and final reports, to consider and take all necessary steps to protect classified information, and

P.C. 2001-569

(vii) be directed to file the papers and records of the inquiry with the Clerk of the Privy Council as soon as is reasonably possible after the conclusion of the inquiry.

CERTIFIED TO BE A TRUE COPY–COPIE CERTIFIÉE CONFORME

CLERK OF THE PRIVY COUNCIL–LE GREFFIER DU CONSEIL PRIVÉ

INTRODUCTION

As Canadians, we feel a strong attachment to a public policy that, for decades, has given us access to a quality health care system on the basis of need rather than income or wealth. We feel this attachment for some very good reasons. Medicare – the portion of health care that is publicly funded and administered – is a remarkable achievement that required vision, leadership, and effective public stewardship to implement and manage. From the beginning, it has required the energy and creativity of deeply committed individuals who work in so many different ways to deliver, manage, support, and improve the services that together we have come to think of as a "health care system."

Last April, I was asked by the Government of Canada to carefully examine the state of public health care in this country and recommend ways it could be made sustainable well into the 21st century. Providing practical and realistic recommendations on how to revitalize the health care system and place it on a more sustainable footing for the future is an enormous task. It is all the more so given the complex and often interrelated nature of the challenges confronting our system and the urgency of dealing with many of them.

The obvious advantage of a one-person Commission is that it is clear who is responsible for sorting through the issues, setting priorities, and making recommendations. At the same time, a one-person, time-limited Commission cannot address every conceivable issue affecting the future of health care in Canada. My objective is to address crucial issues such as the vision and values we want to guide our health system, how we can ensure stable, long-term funding, and what changes need to be made in how we govern the health system. With these major issues addressed, I believe those who have a stake in its future will be in a better position to resolve many of its day-to-day problems.

In keeping with that objective, my priorities are to:

- Propose a compelling and galvanizing vision for the future of health care that takes account of the values and approaches Canadians say they want their health system to reflect;
- Suggest ways in which governments can work together to address some of the more immediate problems that are undermining the stability of public health care;
- Provide a diagnosis of some of the system's underlying and important structural problems and recommend what I see as policy changes necessary to improve public health care in the long run;
- Suggest new approaches for facilitating cooperation and collaboration among all participants of the health system.

Over the past few months, I have heard from Canadians from coast to coast, listened to experts and advocates, met with or spoken to premiers and government leaders, and learned as much as I can about the issues and options that face us today. My work is now at an important turning point. The preliminary, fact-finding phase has come to an end and the next phase, consulting with Canadians, is set to begin. More detailed information on the consultation phase is outlined later in this report.

In many ways, doing an interim report is a challenge in itself. On the one hand, there is so much to say given the wealth of information and experiences gathered from the fact-finding phase of my work. On the other hand, it is still early days. Consultations with Canadians are yet to come. And it is too soon to take hard and fast positions that may not hold up in the light of what Canadians have to say. And so with this Interim Report I have chosen to provide some initial observations on the challenges ahead, to pose some important questions for Canadians to reflect upon, and to set the stage for engaging Canadians in a comprehensive dialogue about the future of their health care system.

As a starting point, my meetings, discussions, travels and conversations with Canadians have confirmed several key points in my mind.

First and foremost, I am convinced that the Medicare house needs remodeling but not demolishing. Medicare was, and continues to be, the right choice. But the mix of publicly available health services currently covered under Medicare needs to be adapted to today's medical realities and delivery systems. When we first started debating Medicare 40 years ago, "medically necessary" health care could be summed up in two words: hospitals and doctors. Today, hospital and physician services account for less than half of the total cost of the system. More money is spent on drugs than on physicians. There are more specialists and more care is delivered in homes, in communities, and through a wide array of health care providers. In short, the practice of health care has evolved. And despite efforts to keep pace, Medicare has not.

Being Clear on Terminology

- ***The Canada Health Act, 1984:*** Provides universal coverage for all medically necessary hospital and physician services.
- **Medicare:** All *Canada Health Act* services plus other publicly financed services provided by provincial health insurance plans. Medicare accounts for about 70% of all health spending in Canada.
- **The Canadian Health Care System:** All Medicare services plus those services purchased or insured privately by individuals or through employers. The share of non-Medicare expenses accounts for approximately 30% of health spending in Canada.
- **The Social and Physical Environment:** The political, economic, social, and environmental conditions (e.g., education, wealth, social status and environmental quality) that allow an individual or population to attain and maintain good health.

Second, Medicare (and perhaps by extension the *Canada Health Act*) has become one of the defining features of our national identity. Some might suggest that this is expecting far too much from a single public policy, especially against a backdrop of rising demands and expectations. In many ways, its iconic status makes it virtually untouchable by any politician. But it also makes it virtually immune to reform, improvement or expansion – and this could, over the long term, diminish one of our proudest national achievements. Just as the Medicare house needs remodeling, we need to ensure that the *Canada Health Act* continues to reflect the values of Canadians and provides a foundation for an evolving health system.

Third, Canadians are worried about the fiscal sustainability of their health care system. There are many different ways of interpreting spending trends and cost pressures. Depending on your perspective, you can conclude that: we need to spend more on health care; or we are on target in that our spending compares favourably with other Organization for Economic Co-operation and Development (OECD) countries; or we have serious problems because we have failed to organize our delivery systems in an effective or efficient way; or we are hurtling toward a budgetary crisis brought on by out-of-control health spending. Cutting across these perspectives is a belief that our health care system has in recent years suffered from inconsistent and erratic funding. Many key health care decisions – from building new facilities, to creating new capacity and delivering certain types of services to target populations – require a long planning cycle. When health care decision makers are obliged to cope with constantly shifting priorities, or when anticipated resources are reduced or eliminated, great uncertainty is the first result quickly followed by reductions in services. This lack of stable, long-term,

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predictable funding is jeopardizing long-term planning and, in turn, eroding public confidence in the system's future.

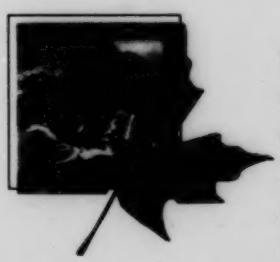
Fourth, while Canadians express concerns about waiting lists and timely access to certain medical services, they also recognize that the health system still provides high quality care. There are many hundreds of innovative new approaches to the delivery of health care across Canada – approaches like telehealth, regionalization, integrated community programs, public-private partnerships, population health approaches, and a myriad of initiatives to improve waiting list management. In fact, there is no shortage of creative new initiatives, pilot projects, and best practices that deserve attention and wider application. The problem is that, too often, these "pilots" do not get off the ground. They are not broadly implemented because of a lack of continuing funding, intergovernmental wrangling or the absence of effective mechanisms for sharing best practices.

Fifth, Canadians want both levels of government to stop the corrosive and unproductive long-distance hollering and finger-pointing that currently passes for debate on how to renew the health care system. They see both levels of government as bearing responsibility for the problems affecting the system and for finding solutions to them. But more than just wanting their governments to work together, Canadians want a say in how these problems get resolved. If difficult choices need to be made, they want to be involved in making them. This is a healthy and positive development.

Finally, it is time for Canadians to be Canadians. We need to be clear on what values Canadians want their health system to reflect in its policies and programs. In the past, progress on these issues has been extremely difficult with intransigent positions taken at both ends of the spectrum. This kind of acrimonious debate does nothing to move us forward to a broader consensus on the direction we want to take or the steps needed to put our health care system on a sustainable footing for the future. We need to be open to new options and ideas, be willing to engage in open and honest debate about the pros and cons of each new idea, then be prepared to act.

We had the foresight to establish Medicare, and I believe we have the intelligence and the will to make necessary decisions about its future. I am deeply committed to sustaining Canada's health care system and ensuring that it continues to reflect Canadians' values. Suffice it to say, the coming months promise to be challenging and exciting ones as we work together to shape the future of Canada's health care system.

2 COMMISSION PROCESS



The work of the Commission is divided into two phases: first, fact-finding, which started in May 2001, followed by a dialogue with Canadians, which begins with the publication of this report. Our fact-finding has been very broadly based and will be ongoing for the duration of my Commission's mandate. We have sought to be as comprehensive as possible in our efforts to mine existing research, understand different perspectives, and listen carefully to the views of the health policy community, governments, and individual Canadians.

The following is a brief summary of our fact-finding efforts to date. More comprehensive information about the fact-finding phase and a list of the many groups and individuals I have met with are included in Appendix A.

UNDERTAKING RESEARCH

Research is an essential component of the Commission's work. The extensive and comprehensive research program of my Commission will be one of its important legacies and will help guide current and future decisions about Canada's health care system.

As part of our research efforts, the Commission has:

- Received and analyzed submissions from health care providers, stakeholder groups, and concerned Canadians who have offered their views on the challenges and opportunities facing public health care in Canada;
- Met with selected national provider, health, business, and academic organizations to obtain their views and perspectives about priority issues;
- Listened to health policy experts at home and abroad;
- Hosted a meeting in Canada of international health policy experts and visited several European countries to learn from their experiences in renewing health care;

- Reviewed and synthesized many relevant studies, reports, and research on health care, both in Canada and elsewhere; and
- Commissioned close to 40 discussion papers from leading health and public policy experts on key issues.

In addition, three research consortiums have been selected to fill in the gaps in our knowledge and understanding in three areas: globalization, fiscal federalism, and human health resources. More detailed information on the Commission's research program is included in Appendix B.

Hearing from Experts and Stakeholders

Over the past months I have had many opportunities to meet with and hear from health policy experts and representatives from the health care community. One of the key challenges will be to sort through the positions, agendas, and recommendations for change from these many knowledgeable individuals and groups. Very early in my fact-finding, I sought the input of a representative selection of stakeholders – provider, consumer, industry, union, and social policy groups operating at a national level – regarding priorities and potential approaches to engage individual Canadians and other groups in a national dialogue on the future of health care. I also asked these national stakeholders to serve as conduits for the views of their regional and local affiliates or members.

Based on these discussions, the Commission developed and posted submission guidelines on its Web site to encourage and facilitate input from individuals or other interested groups. The Commission will carefully review all submissions and take account of their contents, positions, and advice. These submissions are available to all Canadians through our Web site.

Hearing from Governments and National Aboriginal Organizations

In the weeks following my appointment, I asked each province and territory, and the five major national Aboriginal organizations in Canada[1] to designate an individual to act as a liaison for the exchange of information with the Commission. The Government of Quebec takes the position that health care is the exclusive responsibility of the provinces, but has nonetheless agreed to share information. Through this network, and through personal contact with premiers, territorial leaders, and aboriginal organizations, my Commission has received much thoughtful information, advice and assistance. And through this liaison, the provinces, territories, and Aboriginal leaders have been kept abreast of Commission activities.

[1] The Assembly of First Nations, The Inuit Tapiriit Kanatami (formerly the Inuit Taparisat), the Metis National Council, the Congress of Aboriginal Peoples, and the Native Women's Association of Canada.

The most profound evidence of our collective concern for the future of public health care is the fact that every Canadian province and territory has either recently completed, has underway, or is about to initiate policy reviews, reform programs and/or consultations with its citizens on one or another aspect of health care. This is in addition to the work of the Standing Senate Committee on Social Affairs, Science and Technology that will shortly be issuing its final report on the role of the federal government in health care, and the important work of the National Forum on Health that reported to the Government of Canada in 1997.

While each effort has its own logic and distinct focus, it is important that the Commission take careful account of what has been said and reported. If individuals or groups in one or another part of Canada have recently expressed their views on a particular health care issue, we encourage them to share these with the Commission. But I also want people to challenge themselves, to challenge traditional perspectives and reflect on the real values and objectives that must form the backbone of Medicare. The Commission will also take careful account of the findings and results of consultative activities and initiatives that have been or may be undertaken by the provinces, territories or Aboriginal groups.

HEARING FROM OTHER COUNTRIES

In November of last year, I had the opportunity to meet in Ottawa with representatives of a dozen countries from the OECD to discuss health reform initiatives underway in their jurisdictions. What quickly became apparent during this meeting is that Canada is not alone in trying to keep its health care system viable and sustainable. Virtually every advanced industrialized country with a publicly funded health system is concerned about rising costs and issues of quality assurance, access, accountability, and leadership.

Following this meeting, I travelled to the United Kingdom, France, and Sweden to investigate how these countries are attempting to cope with some of these problems. In London, I attended a day-long roundtable with British health experts to hear in detail about the changes underway in the organization and financing of their National Health Service. A similar roundtable in Paris brought together experts from across Western Europe to examine the role of co-payments and their impact on access to and quality of health services. In Stockholm, I met with both government officials and health policy experts to discuss various aspects of the changes underway in that country. Visits to health facilities allowed me to see the operation of the Swedish health system first-hand.

It is unlikely that, in the end, Canada will be able to simply import solutions from abroad. Each country's history and political context is different and, ultimately, each country needs to adopt policies that fit best with its particular values and aspirations.

But I believe we still have much to learn from the experiences and insights of other countries. As part of the Commission's ongoing research program, we will continue to examine those experiences and incorporate relevant findings into our final recommendations.

HEARING FROM CANADIANS

In the final analysis, my recommendations will reflect what Canadians want and expect from their health system, now and in the future. From my discussions to date, it is clear that Canadians care deeply about public health care. Over the past months, I have had the opportunity to hear from many concerned citizens who have taken the time to share their views with me through letters, via e-mail, through our interactive Web site and toll-free number. I have also visited various communities across the country to get a first-hand sense of the many innovative and unique approaches underway to improve the delivery of health care services.

Among other things, Canadians want to ensure timely access to quality services, to reduce pressures on hospitals, to know that the system is more accountable, and to be sure that their tax dollars for health are being spent according to a well thought-out plan that ensures value for money. Canadians are not looking for a quick fix. They want a public health care system that will stand the test of time.

In the coming months, I plan to consult extensively on these issues, on the basic direction for change, and the enduring values they want to see reflected in public health care. More detailed information about consultation plans is included in Appendix C.

ADDRESSING FOUR KEY THEMES

I have organized my work around four important themes:

1. Canadian values and how they are and should be reflected in the *Canada Health Act;*
2. Sustainability and funding;
3. Quality and access; and
4. Leadership, collaboration, and responsibility.

The following sections outline some of what I have heard and learned in relation to these four themes, provide some of my initial observations, and challenge Canadians to begin thinking about some important questions as we start the consultation phase.

Canadians want and expect leadership. They want problems to be addressed and decisions to be made. And although they may lack the technical expertise or knowledge to articulate prescriptive policies, they expect the decisions that are made to be consistent with the values they share. So let's begin there… with a discussion of values and how they shape our views on health care policy.

Values and How They Shape Canadians' Views

The Role of Values

The values we hold play a central role in defining how we view the critical issues facing the future of health care. They play a central role in deciding which problems should have the highest priority, which options are acceptable, and in shaping the solutions we choose to adopt.

During my fact-finding, I have discovered there is no shortage of ideas on what should be done to preserve public health care. Among the many views and options that have been put forward, there are areas of consensus as well as areas of disagreement.

Almost all Canadians I have heard from to date want to ensure that the poorest in our society have access to health care. They also believe Canadians should not be bankrupted by the costs of acquiring needed health care services, and that all Canadians should be protected against catastrophic illnesses and injuries. Most think that need should always be taken into account, with a majority convinced that it should be the sole factor in determining what core of medically necessary services the system should cover. Most also believe that both orders of government must play a role in reforming the current system.

The problem is that when we probe into these areas of supposed agreement, the consensus begins to unravel. Often, these disagreements express themselves as different options for fixing health care. Always, there are significant value judgements lying behind people's views on which options are acceptable and which are not.

Coming to grips with the language of the debate is a particular challenge. Too often, people interpret or understand key terms in fundamentally different ways. This creates misunderstanding and accentuates the real disparities that exist. Take the word "need" for example. Some equate "need" with an individual's own views or preferences – what they want is, by definition, what they need. In terms of access to a magnetic resonance imaging (MRI), for example, it means that you should be the judge of whether you get this test.

Others say that "need" can only be determined by a skilled and knowledgeable professional who gives due weight to the patient's individual circumstances. This would mean that your specialist would decide whether you need an MRI, as well as your place on the waiting list.

Still others argue that "need" should be based on more "objective" assessments, generally defined as statistical evidence based on a large number of similar cases. This would mean that your physician's judgement would be compared with overall assessments, standards, and guidelines.

The word "fair" presents a similar problem. Canadians agree that the benefits of public health care should be fairly distributed. But what is "fair?" It could be "equality of opportunity," "equality of outcome," or even "merit" in terms of deserving or not deserving the service.

"Access" and "portability" are other key health care terms whose interpretation has potentially far-reaching consequences. When we talk about "access," some would say that access alone is not sufficient unless it is also timely. For some, "portability" means they should be able to go from one province to the next and receive health services without having to pay. For others, "portability" means that the same or a similar basket of health services should be available in every province. The list of confusing interpretations of basic words used so often in our health system could go on and on.

What leads to these diverse interpretations? They are based on different, and sometimes conflicting, underlying values. Values shape our opinions about whether we are spending too much or not enough of provincial and federal revenues on health care. Values shape our views about the role the private sector might play in health care, the way in which disparities in health outcomes and health status should be addressed, and the responsibility individuals should take for their own health. They shape whether we think freedom of choice should be an essential component of the health system or whether the principle of universal access should guide our decisions even if that means fewer choices for individuals. Values also shape the way we look at the overall system and decide what is working well and what is not.

FOUR PERSPECTIVES ON THE FUTURE OF HEALTH CARE

Fundamentally, our values determine what we think of the health system, how we think it should change, and whether we think radical change or fine-tuning is necessary. Because health care can affect our every day lives and the lives of family and friends, we are likely to have strong opinions, assumptions, and values. And even if we can only think of how a small part of the system could be improved, we would like to believe that there are viable and complete solutions for the entire system.

In my fact-finding, I was struck by the extent to which people's views on how to address the challenges confronting health care seemed to coalesce around four major perspectives. These perspectives are summarized below:

1. More Public Investment

One perspective is that public health care has been deprived of adequate funding for years and this has damaged what was considered a model system in the world. Supporters are convinced that, with more funding, we can repair the damage that has been done and deliver high quality services. The system would work well if only it had more money. The solution, then, lies in adding more resources (including doctors, nurses and equipment) by increasing public spending, either through a tax increase or by reallocating funds from other government programs.

2. Share Costs and Responsibilities

A second perspective is that our current system will collapse under the weight of unsustainable costs due to new technologies, new health problems, new expectations and improper use. Advocates think paying more taxes will threaten our economic competitiveness in a global economy. A better solution is to add more resources to deal with current problems, not by increasing public spending, but by asking individual Canadians to bear greater responsibility for the costs of health services through options such as co-payments, user fees, taxable benefits or private insurance.

3. Increase Private Choice

A third view is that the discipline of the marketplace would improve the system's effectiveness, efficiency, productivity, and consumer satisfaction. Advocates of this view want a health system that gives Canadians increased choice by allowing them to access private providers of health care services. Side-by-side with the public system, Canadians also could access services from for-profit private sector providers and pay for them from their own resources or through private insurance. Supporters believe that this approach would relieve pressure on the public system and introduce a more entrepreneurial ethic into health care that spurs greater private investment and innovation.

4. Reorganize Service Delivery

The fourth perspective favours fundamentally reforming the organization and delivery of health care with the ultimate objective of integrating all services in a seamless manner. Advocates of this perspective argue that the

traditional "fee-for-service" system for paying doctors is an outmoded concept that provides few incentives to focus on "wellness" and often leads to inappropriate and more expensive care. For example, one recommendation would involve patients registering with what would become a network of community-based health facilities providing more timely and accessible care by the right providers. Funding of these centres could be designed to create incentives for providers to work efficiently and focus on prevention.

Each of these perspectives places an emphasis on different problems in the current system and presents a different framework for reviewing the future of health care in Canada. This, in turn, leads to different views on what the best solutions might be. In reality, it is doubtful that any one perspective, however logical or persuasive, provides a complete solution for our health care system.

Looking at the four perspectives, some might see value in parts of each and think that the solution lies in bringing together the best of each of the perspectives. This likely cannot be done because conflicting values may be embedded in some of these perspectives. Nonetheless, the different perspectives are helpful in clarifying our choices, as well as revealing the values attached to these choices. They provide a starting point for reviewing critical issues in today's health system and in taking the next step in our collective journey toward a solution. These perspectives will be explored more fully as part of our consultation process. Canadians' values and their views on which of these four perspectives most closely matches their own will help shape the solutions proposed in the Commission's final report.

VALUES AND THE *CANADA HEALTH ACT*

The question of Canadians' values and the perspectives people may have on the best solutions to the challenges confronting our health system leads us directly to a discussion of the *Canada Health Act.* For many Canadians the concept of Medicare, as expressed by the *Canada Health Act,* is a defining aspect of their citizenship. And yet questions are being asked about whether the core principles of the *Canada Health Act* continue to be relevant in the face of today's rapidly changing health system. How was the *Canada Health Act* developed? What are the five principles and what do they mean? How should we make decisions when there are differing views about how to interpret the Act?

Some Background on the *Canada Health Act*

Some lessons on the evolution of Medicare and the origins of the *Canada Health Act* provide an important backdrop for discussions about its future.

The first step toward universal public coverage began with the introduction of hospitalization insurance in Saskatchewan in 1947. In 1957, the federal government

committed to sharing the costs of hospitalization insurance with the provinces. This financial assistance encouraged the eventual creation of similar medicare programs in all provinces by 1961.

It quickly became apparent that if the goal was to protect Canadians' health, it made sense to extend public funding beyond hospitalization insurance to include family physicians. Two quite different approaches were proposed:

1. A multi-payer system that encouraged Canadians to purchase the private insurance of their choice (or pay out of pocket if they chose not to buy any insurance), while providing some public coverage to the poorest in society;
2. A single-payer system that provided universal coverage to everyone on the same basis (without out-of-pocket user payments) and was funded through the tax system.

The debate among health care providers, policy experts, and governments about the two options was fierce. The public was both torn and confused by the controversy. In 1964, a Royal Commission on Health Services, chaired by Justice Emmett Hall, rejected the multi-payer approach in favour of a single-payer system primarily for two reasons: it was less expensive and people with poor health and those who were less well off would be better served.

It would take another eight years and considerable debate for the Hall Commission recommendation to be implemented. In the 1960s and 1970s, all provinces eventually dropped a private insurance model in favour of a public model. The majority of Canadians eventually concluded that a public model better reflected the value of equitable and unimpeded access to necessary hospital and physician services by tying access to need rather than ability to pay.

Getting to Medicare: Controversy and Compromise

- **1961:** Conservative Prime Minister John Diefenbaker appoints Supreme Court Justice Emmett Hall to head the Royal Commission on Health Services.
- **1962:** CCF Premier Woodrow Lloyd extends universal, publicly financed insurance to physician services in Saskatchewan followed by a doctors' strike that lasts 23 days.
- **1964:** Emmett Hall's report recommends publicly-funded, universal insurance not only for doctor services, but also for prescription drugs and home care as well as dental and optical services for some groups.
- **1966:** Prime Minister Lester Pearson's Liberal government introduces the *Medical Care Act* – quickly dubbed "Medicare."
- **1968-1972:** Through an intense series of intergovernmental negotiations, all ten provinces and two territories eventually "sign-on" to Medicare, agreeing to provide universal public coverage for hospital and physician care in exchange for federal contributions toward the costs.

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In 1985, mainly in response to a simmering dispute over extra-billing (charging patients in excess of the rates covered by public insurance), Parliament passed the *Canada Health Act*[2] and, for the first time, some of the motivating principles behind national Medicare were made explicit. The principles found tremendous resonance among Canadians and the *Canada Health Act* very quickly achieved iconic status.

The Five Principles

The five principles of the *Canada Health Act* have loomed large in the way we have come to view Medicare. Contrary to what many Canadians think, however, the five principles – public administration, comprehensiveness, universality, portability and accessibility – are not fully defined or described in the legislation. There is significant flexibility in how to interpret the meaning of the principles.

Five Principles of the *Canada Health Act*

1. **Public Administration** – The administration of the health care insurance plan of a province or territory must be carried out on a non-profit basis by a public authority.
2. **Comprehensiveness** – All medically necessary services provided by hospitals and doctors must be insured.
3. **Universality** – All insured persons in the province or territory must be entitled to public health insurance coverage on uniform terms and conditions.
4. **Portability** – Coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country.
5. **Accessibility** – Reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers.

The description we have used for the five principles is taken from Health Canada and is consistent with the language used in other national reports. However, more detailed descriptions are included in the legislation, S.8-12.

The principles themselves underscore many of the values Canadians hold in relation to their health system. But they also have some inherent limitations. First, the *Canada Health Act* covers only hospital and physician services. Innovations in treatment like preventive health programs and community-based initiatives are not generally covered, nor are home care, long-term care, dental care and prescription drug therapies (unless provided in hospitals). Second, there is genuine disagreement over how to interpret these broad principles and what is meant by terms such as "medically necessary" or "accessibility." The interpretation of these principles has been the subject of disputes

[2] *Canada Health Act*, 1984, R.S.C. 1985, Chapter C-6.

between federal and provincial governments. Currently, the federal government has exclusive responsibility for interpreting the *Canada Health Act*. Furthermore, there are significant differences among the provinces in terms of how they individually understand and apply the principles.

Dispute Avoidance and Resolution

In recent years, the volatile issue of how to interpret the *Canada Health Act* has been an ongoing source of intergovernmental friction. For example, the prohibition on extra-billing under the *Canada Health Act* is interpreted by some as absolute and by others as only a limit on the extent of the practice. Because of this type of disagreement over interpretation, there have been calls to revisit the *Canada Health Act* with a view to establishing new mechanisms or approaches for resolving disputes rather than leaving decisions solely in the hands of the federal government.

Debate on Dispute Avoidance and Resolution

Those who support the need for a new dispute avoidance and resolution process argue that:

- Having the federal government solely responsible for interpretation of the *Canada Health Act* leaves it in the position of serving as judge and jury and does not respect the provinces' responsibilities for delivering health care services.
- Given our parliamentary system, the interpretation of the *Canada Health Act* depends on the whim of whatever party happens to be in power.
- A more inclusive dispute avoidance and resolution process is required, one that takes into account patient/consumer needs, the advice of medical experts, and the views of individual Canadians.

On the other hand, there are those who say the federal government should continue to have sole responsibility for interpreting the *Canada Health Act* and resolving disputes. They argue that:

- The *Canada Health Act* is federal legislation and the federal government is in the best position to defend and interpret the Act on behalf of all Canadians.
- The parliamentary system includes sufficient checks and balances to preclude inappropriate or uneven interpretations.
- A multi-party process would sink to the lowest common denominator of agreement and, over time, the meaning of the Act and its enforcement would be diluted.

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Scope of Health Services Covered

Currently, Canadians have 100% coverage for a core basket of hospital, physician, and some directly related services that are defined as medically necessary. The assumption behind this policy is that it is more important to cover the most urgent, essential and costly services rather than those that are considered less necessary. As a result, there are only minor variations across the country in terms of the types of services covered by the *Canada Health Act*. There is, though, an increasing array of health services available to Canadians that go beyond "medically necessary hospital and doctor services." For many Canadians, this has blurred the line between which services are "*Canada Health Act* services" and which are not, but might be provided by a provincial health system. The question of coverage for health care services other than hospital and physician services has been left to individual provinces and their citizens to decide. As a result, there is uneven coverage for additional services such as home care or long-term care across the country.

Variations in Providing non-*Canada Health Act* Services

Although it is difficult to get up-to-date and accurate information about health services that are not included as medically necessary services under the *Canada Health Act*, there are clearly inconsistencies in coverage across the various provinces. Home care is one example where coverage varies considerably. While all provinces and territories cover professional services such as nursing care, some also provide personal care and homemaking. Some provide meals, home management, and maintenance programs while others do not. And some provide respite and palliative care in the home while others do not. Home care programs not only vary across the provinces; there also can be variations within provinces in the types of services provided in different health regions and communities.

While there continues to be much support for the concept of comprehensive coverage under Medicare, it has come under question from two sides. On one side, some argue that the definition of comprehensiveness must be expanded to better reflect the profound changes in medical knowledge, practices, and public expectations over the last 40 years. These concerns lead some to argue that public coverage must be expanded to embrace new services they would now see as medically necessary, such as prescription drugs and some forms of home care. The question of how to pay for these additional services is an important one; if we broaden the scope of what is covered, the costs to public treasuries will increase in the short run even if total health care costs decline in the long run.

On the other side, the explosion in medical technologies and knowledge, coupled with an aging population, has convinced others that we can no longer afford the current services being offered, let alone new ones. This view supports the need for limits on what is publicly covered and what is not. If only the most expensive, life-saving, and essential treatments and tests are publicly covered, then individuals would have to bear greater responsibility for services that are not covered through options such as supplementary insurance or direct user payments.

The question of what gets covered by Medicare and what does not also begs the controversial question about the role of the private sector in the delivery of health care services. When we talk about a "public health system" or Medicare, we are referring to the approximately 70% of total health care spending in Canada that is publicly financed. But governments actually deliver very few of these services directly and, in this sense, elements of our delivery system are already, and have always been, "private."

The *Canada Health Act*: Should It Be Revisited?

Those who support revisiting the *Canada Health Act* say:

- The Act is limited to hospital and physician services and should be revisited to decide whether coverage should be extended to other important health services, including home care, long-term care, and certain prevention and promotion initiatives.
- There is a need for more inclusive mechanisms for deciding what is or is not covered.
- The five principles may be a barrier to ongoing innovation and continuous improvements in the quality of health care services.
- The Act needs to better reflect the role of the provinces in delivering health care services.
- The Act is unclear as to what role the private sector may or may not play and this needs to be clarified.

On the other side of the debate, those against revisiting the *Canada Health Act* argue:

- The Act has served as an effective bulwark against those seeking to diminish Medicare and the principles on which it is based.
- Revisiting the Act will only lead to divisive debates and threats to the foundation of Medicare.
- As a statement of principles, the Act provides the best option for allowing flexible and innovative approaches to the delivery of care.
- The Act has proven that it does not impede the provinces from tailoring their health programs, policies and approaches to local circumstances and requirements.
- Revisiting the Act could open the door to a two-tiered system or more private health care.

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- The Act has proven that it does not impede the provinces from tailoring their health programs, policies and approaches to local circumstances and requirements.
- Revisiting the Act could open the door to a two-tiered system or more private health care.

Governments certainly administer a large portion of Canadians' spending on health care and they play a critical role in protecting public health and safety. But our health care system is a mixed bag of non-profit and for-profit, self-employed practitioners and salaried professionals, unionized and non-unionized workers, and government and private financing mechanisms that all make up the confusing and complex suite of policies, programs and initiatives we call the Canadian health system. In our debates about the future of health care in our country, we need to keep this context in mind when we discuss the role of the private sector in the delivery of health care services.

Debating the *Canada Health Act*

Increasingly, Canadians and the governments who represent them are beginning to debate important questions that go to the heart of the *Canada Health Act*. Is the Act still a valid and sufficient framework for Canadian health care in the 21st century? If not, what should the foundation of the system be and what principles should guide its operation? Should we define more explicitly what the five principles of the *Canada Health Act* mean?

There are strong and conflicting views on whether or not it is time to revisit the *Canada Health Act*.

INITIAL OBSERVATIONS

Canadians have come to view Medicare – and its legislative core, the *Canada Health Act* – as a defining feature of Canadian society. At the same time, most Canadians recognize that no piece of legislation should be immune from review and re-thinking. The goal is not to renounce the principles we hold dear but to ensure that the *Canada Health Act* is a beacon for the future direction of the health system, not a barrier to change or a lightning rod for intergovernmental squabbling.

In that light, my initial observations are as follows:

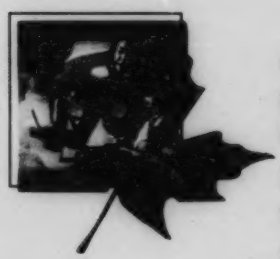
- The *Canada Health Act* needs to be debated to ensure it still expresses the values Canadians share and provides a clear, coherent, and modern vision for our health system.
- We need to consider establishing a new mechanism or approaches for heading off or resolving disputes about the interpretation of the *Canada Health Act*.
- Canadians need a greater say in determining what health services should or should not be publicly covered. Although elected governments must always retain accountability, the ways in which decisions are currently made, and who is making them, are difficult to understand and often even more difficult to justify.

SOME QUESTIONS FOR CANADIANS

In the context of Canadians' values and their views about the future of the health system, I would like people to think about several important questions:

- *What are the fundamental values that should underpin the* Canada Health Act*?*
- *Are the principles set out in the* Canada Health Act *consistent, relevant, and appropriate to the contemporary challenges facing our health care system?*
- *Are the principles sufficient to achieve the priorities Canadians have for improved quality of care and better, timelier access to health services?*
- *How should disputes over interpretation of the* Canada Health Act *be resolved?*
- *How should we decide what precise medical procedures and services should be covered by Medicare?*
- *Can Canadians play a more direct role in determining what additional services can or should be covered under Medicare, including, for example, home care, long-term care or pharmacare?*

4 FUNDING AND FISCAL SUSTAINABILITY



In my discussions with Canadians, with experts and stakeholders, and with political leaders, I have heard profound concerns about the adequacy of public funding for health care given current and, more importantly, future cost pressures. They worry about whether we can afford to meet the health care needs of an aging population. They worry about whether we can afford the increasing costs of new drugs, treatments, and cures. And some Canadians are concerned that increased public spending on health care is beginning to crowd out public investment in other areas such as education, social services or housing.

The question of fiscal sustainability is central to the Commission's mandate. The issues are complex and, in many cases, there is no consensus on basic questions such as the relative shares of provincial and federal funding, how best to address trends in funding, and whether we are spending too little or too much of provincial and federal budgets on health care.

For the purposes of this Interim Report, and to get Canadians thinking about the fiscal challenges, it is important to begin with a snapshot of the fiscal situation, some of the factors that are driving costs, how we fund the health care system today, and the options we might consider for ensuring sustainable and stable funding for the future.

A FISCAL SNAPSHOT

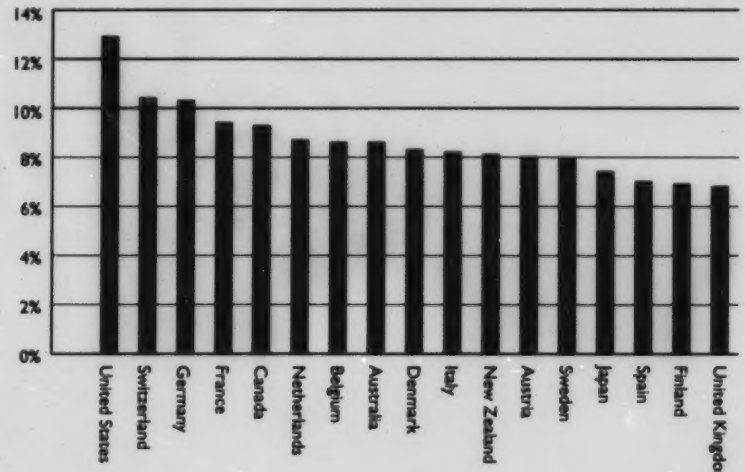
What do we know about health care spending in Canada? Are we spending too much or not enough? Frankly, there is no consensus and the answer depends on the financial approach you take and how you look at the numbers. However, there is some clear evidence available.

How Does Canada's Spending Compare with Other Countries?

If we examine total health spending (from both public and private sources) as a percentage of Gross Domestic Product (GDP), Canada is in the top third of the advanced industrial countries in the world (see Chart 1a). Unfortunately, there is no immediate or direct relationship between health care spending on the one hand and the health of a given population on the other. For example, while the United States spends the most on health care and the United Kingdom the least (among the countries shown), it is not evident that these differences result in one country having a healthier population than others.

Chart 1a

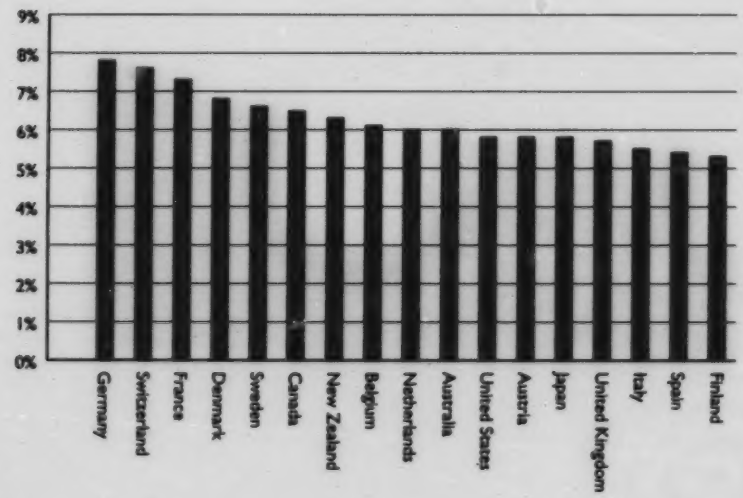
Total Health Expenditures as a Percentage of GDP Among Selected OECD Countries



Source: OECD health data 2001.

Chart 1b

Total Public Health Expenditures as a Percentage of GDP



Source: OECD health data 2001.

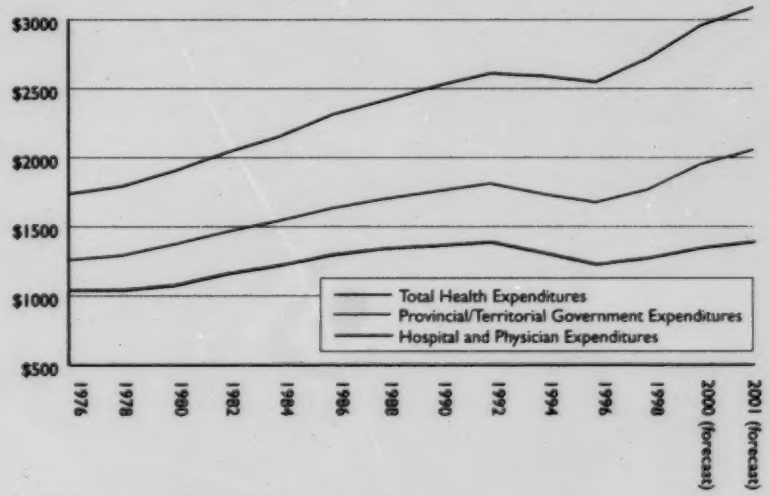
When we look at only the publicly funded share of health care expenditures, we see that Canada is again in the top third of countries in terms of its health care investment (see Chart 1b). At the same time, it is remarkable how closely most OECD countries resemble each other in terms of health care spending.

Are We Spending More or Less than in the Past?

Chart 2 shows that, adjusting for inflation, total health spending has clearly grown over the past decades. Real health expenditures (increases in spending minus the rate of inflation) increased steadily until the early 1990s when there was a marked slowdown in provincial government spending on health. Total health expenditures again began to increase significantly after about 1997. It appears that most of the recent increases in total health spending are accounted for by factors other than hospital and physician services. In other words, the non-covered *Canada Health Act* portion of health spending is rising faster than the *Canada Health Act* covered portion.

Chart 2

Per Capita Health Expenditures: Total Health, Provincial-Territorial Health Expenditures, Hospital and Physician Services Expenditures (Constant 1997 $)



Source: Canadian Institute for Health Information (2001), "National Health Expenditure Trends, 1975-2001."

Do We Provide Stable Funding for Health Care?

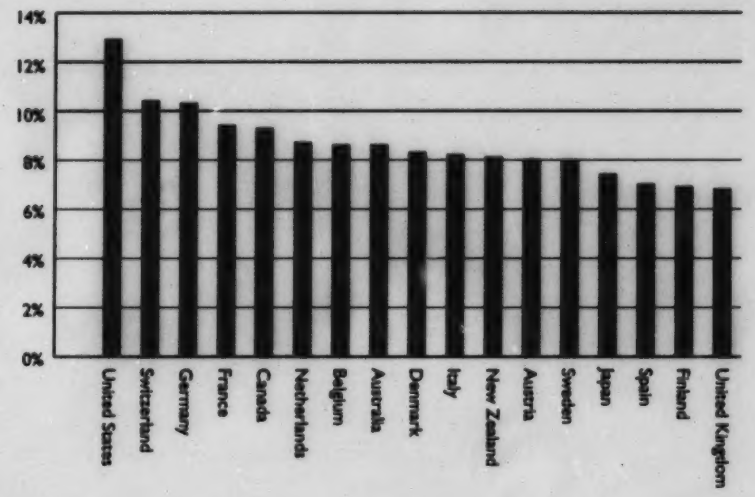
If you look at changes in spending on health care from one year to the next, Canada's annual increases or decreases in spending vary more significantly from year

How Does Canada's Spending Compare with Other Countries?

If we examine total health spending (from both public and private sources) as a percentage of Gross Domestic Product (GDP), Canada is in the top third of the advanced industrial countries in the world (see Chart 1a). Unfortunately, there is no immediate or direct relationship between health care spending on the one hand and the health of a given population on the other. For example, while the United States spends the most on health care and the United Kingdom the least (among the countries shown), it is not evident that these differences result in one country having a healthier population than others.

Chart 1a

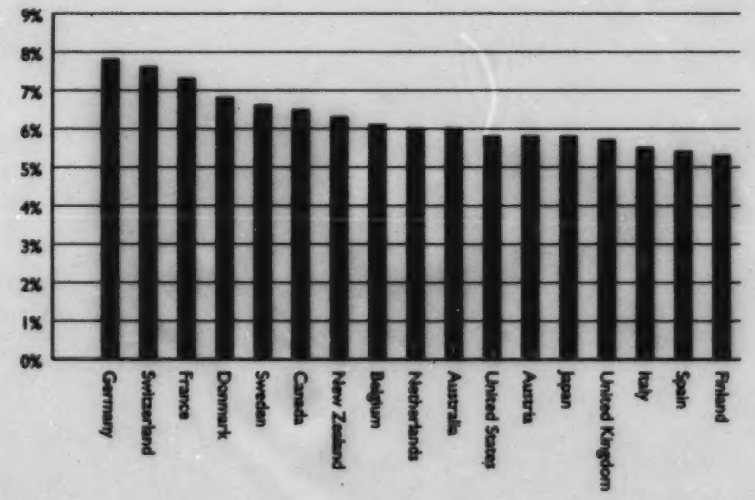
Total Health Expenditures as a Percentage of GDP Among Selected OECD Countries



Source: OECD health data 2001.

Chart 1b

Total Public Health Expenditures as a Percentage of GDP



Source: OECD health data 2001.

When we look at only the publicly funded share of health care expenditures, we see that Canada is again in the top third of countries in terms of its health care investment (see Chart 1b). At the same time, it is remarkable how closely most OECD countries resemble each other in terms of health care spending.

Are We Spending More or Less than in the Past?

Chart 2 shows that, adjusting for inflation, total health spending has clearly grown over the past decades. Real health expenditures (increases in spending minus the rate of inflation) increased steadily until the early 1990s when there was a marked slowdown in provincial government spending on health. Total health expenditures again began to increase significantly after about 1997. It appears that most of the recent increases in total health spending are accounted for by factors other than hospital and physician services. In other words, the non-covered *Canada Health Act* portion of health spending is rising faster than the *Canada Health Act* covered portion.

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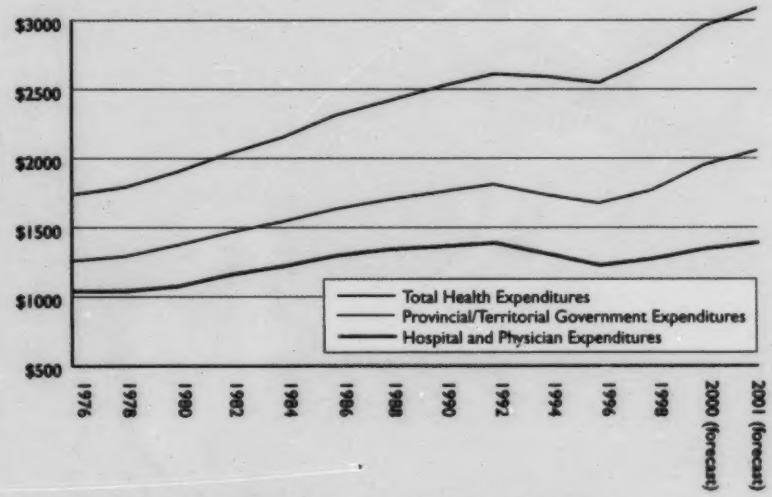


Source: Canadian Institute for Health Information (2001), "National Health Expenditure Trends, 1975-2001."

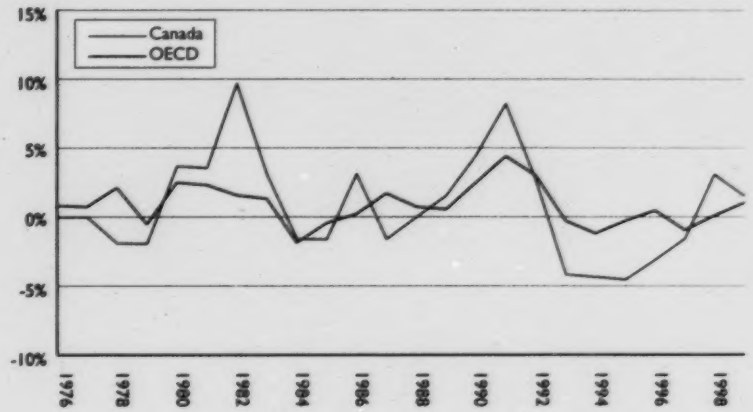
Do We Provide Stable Funding for Health Care?

If you look at changes in spending on health care from one year to the next, Canada's annual increases or decreases in spending vary more significantly from year

to year than other OECD countries (see Chart 3). This would seem to reinforce the arguments of those who say that unstable and unpredictable funding is a significant challenge for health care planners in Canada.

Chart 3

Annual Rate of Change: Public Health Expenditures as a Percentage of GDP

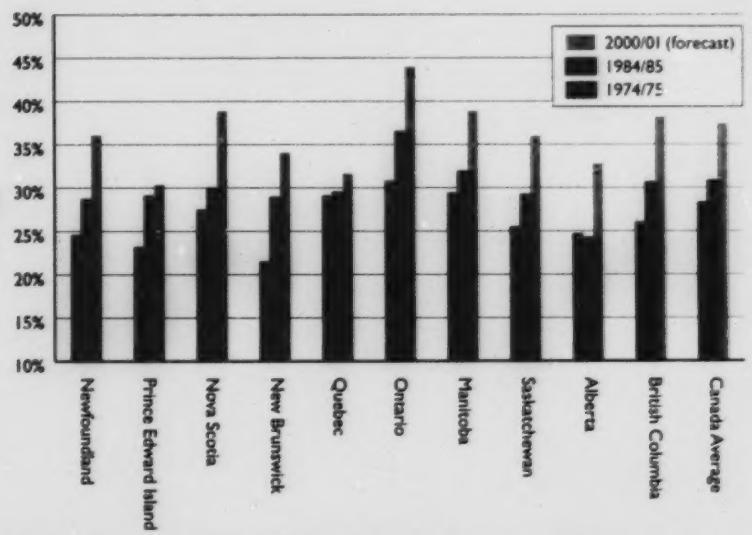


Source: OECD health data 2001.

Note: OECD is calculated on the rate of change among a select group of OECD countries including Austria, Canada, Denmark, France, Finland, Germany, Italy, Japan, Netherlands, New Zealand, Spain, Sweden, Switzerland, United Kingdom and the United States.

Chart 4

Preliminary Provincial Government Health Expenditures as a Proportion of Provincial Government Programs (Current $)



Source: Canadian Institute for Health Information (2001), "Preliminary Provincial/Territorial Government Health Expenditure Estimates, 1974/75 to 2001/02."

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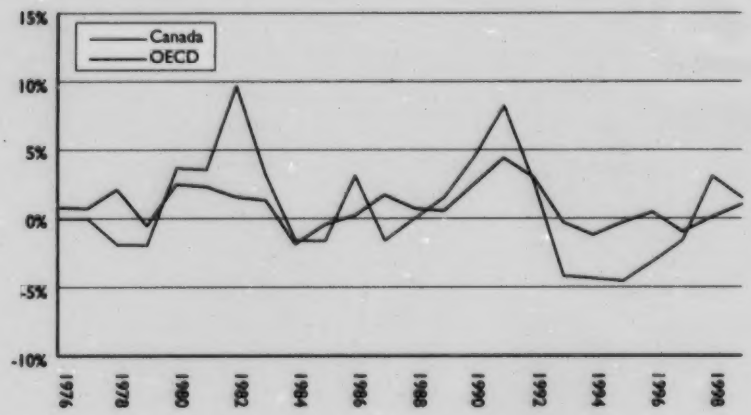

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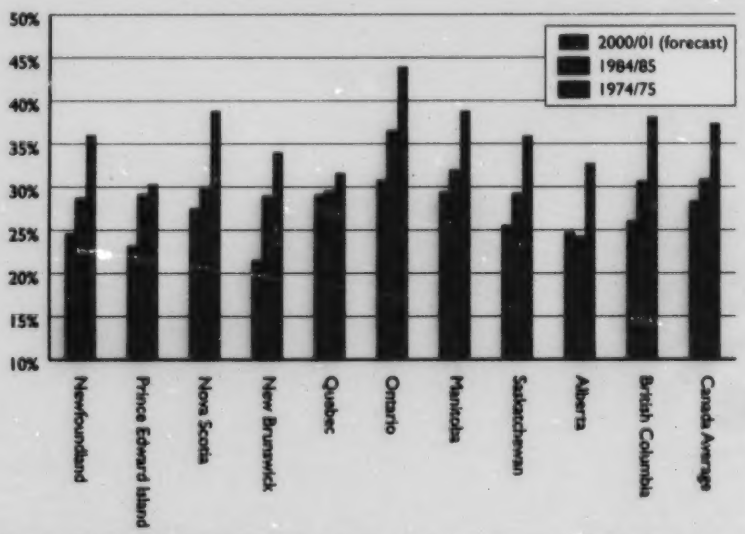

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Is Health Care Taking Up an Increasing Share of Provincial Budgets?

Some Canadians and their governments are worried that the requirements of the health care system are crowding out other essential services. Currently, provinces devote at least 30% of their program spending to health, and for some, the proportion is more than 40% (see Chart 4). For all provinces, the proportion of their program spending that goes to health has increased considerably since the mid-1970s. For many governments, this is a growing concern. All provinces and territories are looking for ways to manage and contain costs in health care. The challenge appears to be the following: What proportion of overall public spending should be dedicated to health care and what happens if spending pressures continue to rise?

Trends in Health Care Costs

Current trends show that costs in health care are increasing. But many suggest that, looking ahead, a combination of several new and emerging factors may drive costs even higher.

New drugs and drug therapies, the growth in diagnostic and therapeutic technology, rapid advances of new technological innovations, and new gene therapies hold enormous potential but will undoubtedly drive costs in the health care system. The aging of Canada's population may also be a factor. There is good evidence that Canadians are living longer and healthier lives and this may reduce the impact of aging on health care costs. However, it is true that health care needs and consumption patterns change significantly as people age.

One of the most significant cost drivers is how our own expectations have grown over the past few decades. We expect the best in terms of technology, treatments, facilities, research and drugs, and as a consequence, we may be placing demands on our governments that are not sustainable over time. Managing expectations and ensuring that Canadians understand the trade-offs involved with increasing public spending on health is a major challenge in designing a sustainable health system for the 21st century.

Paying for the Health System

For many Canadians, the details of how we pay for health services are murky at best – and for good reason. The arrangements are complex and confusing. Some services are publicly insured and others are not. Voluntary private insurance pays for all or a part of certain services. Some services are publicly paid for in some provinces but not in others. Provincial and territorial governments raise money for health care primarily from income tax but also from a variety of other sources including sales taxes, health care

Collecting and Spending Health Care Dollars: Who Does What?

Citizens	Federal Government	Provinces/Territories
• Payment of federal taxes • Payment of provincial taxes • Direct purchase of private insurance (often through employers) • Direct purchase of medical and non-medical services	• Canada Health and Social Transfer (to provinces) • Equalization support to less wealthy provinces • Programs for medical and non-medical research and public health • Direct health services for selected Aboriginal populations, veterans, military personnel, etc.	• Program and service payments to providers, institutions and health authorities for "medically necessary" doctor and hospital services under the *Canada Health Act* • Supplementary programs not covered by the *Canada Health Act* (home care, long-term care, drug coverage for some residents, etc.) • Programs for medical and non-medical research and public health

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In recent years, there has been considerable discussion and debate about how much the federal government contributes to meeting the costs of health care services across the country. Not only do the federal and provincial governments disagree on whether the federal contribution is "sufficient," but they also disagree on what counts as a transfer from the federal government to the provinces. As a result, each side in the debate uses its own facts and figures and insists that "the other guy" is the source of the problem. It is no wonder that Canadians often express anger and frustration at both orders of government and their apparent inability to find common ground to resolve these issues on a long-term basis.

FISCAL OPTIONS

In many ways, what we do to ensure fiscal sustainability depends on how we define the problem and the values we bring to the discussion. Looking back to the four value perspectives outlined earlier on page 11, the solutions and fiscal options people support are tied directly to their views on the nature of the problem.

If people think the fiscal problems we face in health care today result from inadequate funding in the past and the need to "catch up," then the solutions lie primarily in increasing federal and provincial funding for the current system.

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If people think costs in health care will continue to grow at dramatic rates, beyond what we can afford from provincial and federal budgets, the solutions may lie in looking for new sources of revenue such as dedicated taxes or surcharges, or asking Canadians to bear more responsibility for health care costs through options such as co-payments, health care premiums, user fees, or other types of individual contributions.

Some people think the public health system cannot be expected to meet all the growing demands and associated costs. They support solutions that provide more choices for people to get health care services in the private sector and pay for it themselves or through private insurance.

Then there are those who think the current fiscal problems are due to flaws in how we organize and deliver health care services. These people support solutions that lie in reorganizing service delivery and implementing innovative approaches such as primary health care.

Overlaying these four perspectives is the issue of the respective roles of the federal and provincial governments in sustaining the health system. As noted earlier, there are differing views on what the relative financial contributions of the two orders of government should be now and in the future.

INITIAL OBSERVATIONS

Regardless of which perspective we hold to be true and how we define the fiscal problems, sustaining our health system clearly is one of the biggest challenges we face as Canadians. To address this challenge, my preliminary views are that:

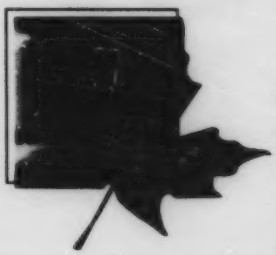
- There is no absolute standard for what any country should spend on health care. The choice will reflect the history, values, and priorities of each.
- There are no simple, easy answers to the issue of funding. Both orders of government make decisions that have an impact on their ability to fund increasing costs in the health care system. The solution does not lie in pointing fingers but in putting a better process in place to determine the relative federal and provincial shares for maintaining a viable and effective health care system.
- Uneven and erratic fluctuations in funding that have plagued the system in the recent past must be replaced with predictable, long-term funding arrangements where the rules and expectations of governments are clear.
- There should be more transparency in terms of how much money is being spent, by whom, on what basis, and with what results.
- Canadians need to have confidence that the existing federal-provincial fiscal arrangements, including the CHST, provide the stability and long-term predictability the system requires.

SOME QUESTIONS FOR CANADIANS

Looking ahead to our consultations, I would like Canadians to think about the following important questions:

- *What relative priority should governments give to public health care programs, recognizing that there is only one taxpayer and that governments face significant competing demands from other areas such as education, roads, security or social services?*
- *Do we need to spend more money on Canada's health care system and if so, where should the additional funding come from? Should it come from provincial and/or federal budgets, from new sources of revenue such as new or dedicated taxes, or should individuals be expected to contribute more to the costs of their own care?*
- *What do you think the relative shares of the federal and provincial governments should be in terms of providing stable, long-term funding for health care?*
- *Are Canadians' expectations of the health system realistic relative to the capacity of federal and provincial treasuries?*

5 QUALITY AND ACCESS



When I talk with Canadians about health care, I repeatedly hear concerns in two areas: quality and access. Canadians want to know that they are getting quality health services – services that cure illnesses, improve quality of life, and improve overall health. People also are worried about waiting – waiting to see a doctor or specialist, waiting for diagnostic tests, waiting for surgeries, or waiting for cancer treatments. Simply put, Canadians worry about whether our public system is keeping pace and providing the quality of care needed. The following are some highlights of concerns raised by Canadians in relation to quality and access to care.

WAITING FOR HEALTH CARE

Excessive delays for health care services have become one of the main worries of Canadians. This can result from many factors including the way we ration access and the ways those responsible for the delivery of health services try to manage within budget limits. There are, no doubt, countless reasons for long waiting lists. One is a shortage of resources, both money and qualified staff, including nurses, family physicians, specialists and technicians. Inefficient management practices may cause some people to wait inordinately long times for treatment. In many cases, the absence of well-defined criteria, careful tracking, and transparent standards can cause unnecessary delays. Another clear impediment is the fact that the parts of the system are not well integrated. Too often, hospitals, doctors, specialists and nurses tend to operate in "silos," working side by side but not as part of the same integrated team with the patient as the focus. We must also keep in mind that continuous improvements in technology make it possible for more people to safely receive new treatments and procedures and this, in turn, puts added pressure on existing facilities and resources.

Concerns about Waiting Lists

- **Specialists** – Waiting months to see a specialist is Canadians' major frustration with health care. The causes range from a shortage of some specialists and poor scheduling practices to inappropriate assessments of need.
- **Diagnostic Procedures** – We have all heard about waiting for an MRI. Waiting for medical imaging, scanning or other tests can take time due to shortages of equipment, specialists and qualified technicians, and pressures caused by increased use.
- **Surgery** – Waiting for elective and non-emergency surgery is common. Delays can be caused by a failure to manage access effectively, a shortage of health professionals, lack of operating room time or a shortage of hospital beds.
- **Emergency Rooms** – Anyone with a very sick child in the middle of the night knows about waiting in emergency rooms. Waiting can result from unanticipated spikes in demand from a major accident or outbreak, unavailability of other options such as after-hours clinics, shortages of staff, non-emergency use of ERs, inability to transfer patients to regular wards, or poor distribution of caseloads with neighbouring facilities.
- **Long-term Care Facilities** – Too often, people who need long-term care wait in hospital. The waiting is caused by a shortage of beds in long-term care, insufficient community care and housing alternatives, and non-standardized admission criteria.

Some Common Access Problems

- **Unavailable Services** – Services (e.g., certain experimental therapy) or technology (e.g. a PET scanner) are simply not offered under a given provincial or territorial plan, with no provision made for sending patients elsewhere.
- **Demand for Services Exceeds Supply** – This triggers rationing based on degree of need or some other criteria.
- **Services Not Conveniently Available** – Some specialized services as well as high-cost capital technologies may only be available in larger urban centres.
- **Services Not Covered under the *Canada Health Act*** – Some services are not publicly covered although they may be essential for treatment such as prescription drugs for some chronic illnesses.
- **Cultural, Linguistic or Class Barriers** – These factors make it very difficult for marginalized groups, including some Aboriginal and immigrant groups, to access health services.

Canadians also are concerned about access to a wide range of health services from a visit to a family physician or a specialist to the need for long-term care or community mental health programs. Problems of access and waiting times are serious ones indeed and serve to undermine the confidence of Canadians that the health system will be there when they need it.

MEASURING OUTCOMES

It is often said that you cannot improve what you cannot measure, and this certainly holds true for the health system. Despite recent efforts, good, reliable, comparable information on far too many aspects of our health care system – from waiting times, to costs, to treatment outcomes – is woefully lacking. While we hear a lot of talk about the importance of evidence-based decision making, there is often very little hard evidence to use to guide decisions. The best evidence we have is anecdotes, past practices, and best guesses.

A variety of new approaches have been suggested in recent years including:

- The creation of a number of common indicators to measure performance from the national system level to the individual clinic;
- Health outcome indicators that look beyond measurements of illness and treatment;
- Innovative health care management tools including clinical guidelines;
- Integrated information management systems.

In the past number of years, progress has been made in both measuring the performance of the system in a meaningful manner and in providing Canadians and their governments with better health information. For example, the Canadian Council on Health Services Accreditation, a not-for-profit non-governmental organization, evaluates care and the quality of health services against a set of national standards. The Canadian Coordinating Office for Health Technology Assessment provides governments with important information on the effectiveness of new technology, and the Canadian Institute for Health Information provides both governments and the public with better and more comprehensive data on health outcomes and the system generally.

DISPARITIES IN ACCESS AND QUALITY

Canadians, who live in rural and remote areas, including our vast northern territories, often feel they are not getting sufficient access to the health services they need. Many do not have convenient access to family physicians and other health professionals and services. Because the majority of Canadians live in southern urban centres, that is where health care resources are concentrated.

While people in remote communities know that their location prevents immediate access to the most specialized physicians and facilities, they do expect reasonable arrangements for necessary medical treatment. They fear that with growing shortages of health providers, it will only get harder to attract the providers needed to serve their communities. Some important actions are being taken to address these concerns. Steps are being taken to recruit and retain health care providers to rural areas and provide incentives for them to stay. Advanced technologies such as telehealth are also being piloted in a number of provinces and have the potential for improving access to specialized services that would not otherwise be available.

Some ideas for addressing these disparities include:

- Establishing integrated networks of care designed for vast distances;
- Making greater use of telemedicine and information technology;
- Finding a better balance between centralized and local control over service delivery and administration.

Innovation and Delivery

In spite of concerns we frequently hear about the health care system, for the majority of Canadians, the system is working. While the focus of media reports, letters to the editor, and talk among neighbours is frequently about things that go wrong, for most people, most of the time, things go right. They get the care they need when they need it. Their health problems are diagnosed and treated. They get well quickly and with a minimum of discomfort.

On top of that, there are literally thousands of innovative and exciting new approaches being tried in communities from coast to coast. Primary health care reform is one of those innovations and it is becoming more widespread across the country. Advances in telehealth are linking surgeons and specialists in major urban centres with family doctors in remote parts of Canada, allowing them to diagnose and treat health problems without leaving their home community. We are gradually making headway in improving Medicare's ability to deal with the challenge of providing effective chronic and long-term care through new community and home care programs that are replacing the need for people to stay in hospitals or move into long-term care facilities. New treatments and cures are coming on stream every day and are improving health and Canadians' quality of care. Unfortunately, the problem is that many of these innovations and new approaches are isolated events, funded as pilot projects, and subject to all the uncertainty that surrounds one-time funding.

In every province across the country, there are literally hundreds of innovative approaches in place to address issues of quality and access. The following sections summarize recent trends in delivering health care services.

Focusing on the Determinants of Health

There is an ever-growing body of evidence that factors such as education, income, poverty, and social exclusion have a significant impact on health outcomes. In addition, increasingly robust population health data allow us to identify segments of the population with a higher than average incidence of certain types of health problems. Both developments enable policy-makers to develop targeted and effective health and social policy initiatives. At the same time, better information about the impact of these broader factors on the health of Canadians leads to wide debate on where the best investments should be made to improve health outcomes. What relative share of governments' investments in health should be focused on prevention of illness and injury, promotion of good health habits, treatment of illnesses, or "healthy" public policy to address the socio-economic and other inequalities that lead to ill health? These issues are difficult for governments to address because mounting costs for acute care services combined with longer waiting lists put pressure on them to spend less on promotion and prevention and more on acute medical services.

Home Care

Advances in medical technology and in drug therapies often mean shorter hospital stays and more treatment for many medical problems at home, at a significantly lower cost to the health system. Currently, there are significant variations in provincial coverage for home care services and evidence that, in some communities, the basic infrastructure (e.g., visiting nurses) to support home care is uneven or non-existent. This has led to growing calls for both orders of government to work collaboratively to develop a more coherent and consistent national home care strategy whose core elements would be funded under Medicare. Supporters of a national approach suggest that enabling patients to receive more treatment at home will improve quality of care, relieve pressures on hospitals, and result in significant savings.

Palliative Care

Quality care toward the end of a person's life has been referred to as a "right of every Canadian." Many feel that greater effort needs to be made to enable terminally ill people to spend the last moments of their lives at home, surrounded by family and friends. There are numerous, innovative, community-based pilot projects underway across the country to help meet this objective. These typically involve teams of health service providers working with families and caregivers to provide services in the most appropriate setting. As with home care, some people suggest that the federal government should take the lead in working with the provinces to develop a national strategy for end-of-life care.

Regional and Community Delivery of Health Services

With the exception of Ontario, all provinces have moved to a system of regionalized delivery of health services. The objective of regionalization is to facilitate more integrated delivery of a range of health services, to provide more responsibility for financial management at the community level, and to encourage more local input to decision making. Combined with this trend, more services are being delivered in community settings rather than in hospitals. For example, mental health services are more frequently delivered in communities. Community health clinics in some communities are providing a comprehensive range of services from emergency care to immunizations, counselling, prenatal care, and prevention and promotion activities.

Primary Health Care Reform

Many believe that to achieve a truly quality-based system, the focus of health care reform should be on addressing community needs. As previously noted, advocates of this type of reform support fundamental changes in the organization and delivery of health care with the ultimate objective of integrating all services in a more seamless manner. Some argue that the traditional "fee-for-service" system for paying doctors is an outmoded concept that provides few incentives to focus on "wellness" and often leads to inappropriate and more expensive care. Some want patients to have the option to register with one of what will eventually become a network of community-based health organizations offering 24 hours a day, 7 days a week access to a range of medical services and specialties. These could include, among others, family physicians, nurses and nurse practitioners, home care workers, dieticians, counsellors, and other providers. There are an endless variety of potential models and approaches, but a common element in most is that governments would fund these organizations based on some combination of the number of registered patients, population served, and the health outcomes achieved. While steps have been taken in every province to initiate primary health care pilot projects, many argue that, because primary health care is the key catalyst to real change in the health system, it is time to move past the rhetoric and pilot projects and into true action.

HEALTH HUMAN RESOURCES

Just one year ago, a pan-Canadian group of health research organizations identified health human resources as one of the key research challenges over the next two to five years. Among the human resources problems they identified were shortages at the local, provincial, national, and international levels of key health professionals, from doctors and nurses to therapists and technicians. They also noted that these shortages were especially acute in remote and rural communities and that low morale was a growing

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- **Delivery** – Expansion of primary care initiatives, regionalization, more health services delivered in communities rather than hospitals, telehealth, expanded use of nurse practitioners and a broader range of health care providers, more services available in the home, expanded palliative care and respite services for family members.

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A variety of options for addressing these problems were proposed, including:

- Permitting a larger and more independent role for nurses, psychologists, physiotherapists, speech therapists and others as part of primary care teams in delivering health care services;
- Reducing the volatility of annual health care budgeting to cut down on the "stop and go" financing that has triggered years of restraint and layoffs fluctuating with years of spending and new hiring;
- Encouraging national or intergovernmental health human resources planning, including education and training, as well as more coordinated long-term forecasting;
- Boosting incentives for health care providers to work (and live, for longer periods) in rural and remote parts of the country;
- Improving morale by ensuring that providers are able to meaningfully participate in the design and implementation of future major health reforms;
- Moving toward an integrated educational curriculum for health providers, including perhaps common courses that would facilitate cooperation and build mutual respect between different types of providers;
- Increasing the supply of health professionals, or changing attitudes and behaviours, is necessarily a long-term proposition.

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problem. Morale problems were attributed to providers working longer hours, under more stressful conditions, and the sense that they were left out of the process of health reforms in the 1990s. Concerns were also reported with respect to scope of practice (health care providers poorly aligned with patient needs and growing turf battles among various health professions) and "poaching" of scarce health professionals across health regions and jurisdictions.

A variety of options for addressing these problems were proposed, including:

- Permitting a larger and more independent role for nurses, psychologists, physiotherapists, speech therapists and others as part of primary care teams in delivering health care services;
- Reducing the volatility of annual health care budgeting to cut down on the "stop and go" financing that has triggered years of restraint and layoffs fluctuating with years of spending and new hiring;
- Encouraging national or intergovernmental health human resources planning, including education and training, as well as more coordinated long-term forecasting;
- Boosting incentives for health care providers to work (and live, for longer periods) in rural and remote parts of the country;
- Improving morale by ensuring that providers are able to meaningfully participate in the design and implementation of future major health reforms;
- Moving toward an integrated educational curriculum for health providers, including perhaps common courses that would facilitate cooperation and build mutual respect between different types of providers;
- Increasing the supply of health professionals, or changing attitudes and behaviours, is necessarily a long-term proposition.

In an effort to contribute solutions for these problems, the Commission has initiated a research project to examine innovative solutions to the system's human resources problems and has also asked individual experts to provide discussion papers on some of these questions. This work will be available to the public on the Commission's Web site.

HEALTH RESEARCH

There has been an explosion of research in a number of new areas including stem cell, human genome, pharmaceutical, and diagnostic and treatment procedures. This research holds tremendous potential for curing illnesses, preventing illnesses, and improving overall quality of life and the health of Canadians. Canada has a highly qualified health research community and has contributed significant new advances to a growing body of research around the world.

Recently Canada has increased its investment in health and medical research with the creation of the Canadian Institutes of Health Research (CIHR). Designed to integrate and coordinate health and medical research, CIHR combined three other research funding organizations into a single granting agency. CIHR provides an important opportunity to capitalize on existing research strengths, improve health, and maintain a competitive advantage in an international, knowledge-based economy.

INITIAL OBSERVATIONS

Whatever changes we make to Canada's health system, they must address Canadians' primary concerns, namely, quality and access.

On a preliminary basis, I would suggest that:

- We need to reinforce our commitment to quality health care – care that is responsive to consumers' needs.
- We need to maintain research as a hallmark of Canada's health system.
- We need to consider new approaches and institutional arrangements for establishing common health priorities, encouraging innovation, sharing information about best practices, coordinating research, and facilitating the adoption of common standards across the health system.
- While steps have been taken to expand knowledge about our health system, more needs to be done to develop and share consistent, comparable, and timely information about health outcomes and improve accountability.
- We need to identify and remove barriers to the expansion of primary care initiatives across the country.

- We need to strike a better balance between treating people when they are sick or injured and focusing on broader "health determinants" that address underlying causes of poor health and have the best potential for improving the overall health of Canadians.
- We need to make decisions on whether or not to establish national policy directions and extend public funding to expand home care and palliative care.
- More needs to be done to invest in prevention and promotion activities, including ways of encouraging individuals to take more responsibility for their own health.
- We need to develop more coherent approaches to address issues of chronic disease management.

Some Questions for Canadians

As we look for the most effective ways of improving quality and access, I want Canadians to consider these questions:

- *Is there merit in setting public targets for performance of our health system and measuring outcomes related to those targets? If so, how would they be set? Who would set them?*
- *How de we balance broader strategies for population health with growing demands and costs for acute medical treatments and procedures?*
- *Is there merit in providing Canadians with some guarantees about the quality of health services they receive or the time they should wait for certain health services? If so, in what form?*
- *Can the Medicare system afford to expand home care, pharmacare and palliative care? Can it afford not to?*
- *How should we address the challenge of ensuring adequate supplies of health professionals?*
- *How do we foster a culture of continuous improvement and innovation?*
- *What can we do to encourage a stronger commitment to, and broader implementation of, primary care models?*

LEADERSHIP, COLLABORATION AND RESPONSIBILITY

Canadians are worried about the health system. As noted in the previous section, their concerns are focused primarily on access and quality. They want to know who is responsible for the level, range, timeliness, and quality of health service in their communities. They want to know that the two orders of government responsible for financing public health care are held accountable for predictable and long-term funding as well as for ensuring the money is well spent. And they want greater transparency in terms of who manages what and what outcomes are achieved.

ROLES AND RESPONSIBILITIES

Talk about roles and responsibilities in health and the discussion inevitably starts with governments, with health regions or health boards, with doctors and nurses. But many Canadians have also come to realize that they can play an important role in maintaining or improving their own health. They are leading more active and healthier lifestyles and have begun to "take charge" of their personal health and that of their families. But there are still important social and economic barriers that prevent some of us from following suit. Health related Internet sites are among the busiest on the World Wide Web, but Internet access is far from universal and poorer, less well-educated Canadians are often unable to take advantage of these important innovations.

Turning to the more traditional roles of governments, we live in a federal state where the powers and responsibilities were divided up by a Constitution whose genesis was in the 1860s. While the principal responsibility for health care under the Constitution falls to the provinces, the federal government retains responsibility for health protection, services to specific groups including Aboriginal peoples, interpreting the *Canada Health Act*, and funding a portion of health care. Both orders of government share responsibility for health education and promotion.

It will take some "give and take" at both provincial and federal levels to clarify respective roles and responsibilities and establish a more collaborative relationship. There are numerous examples where intergovernmental cooperation is in place and is producing reasonable results. Ministers and deputy ministers of health across the country meet regularly and often share ideas and agree on broad policy directions. The Canadian Institute for Health Information (CIHI), funded by both orders of government, has a mandate to compile and share information about health and health outcomes and to foster common data and information standards. And there are cooperative arrangements in place to look at waiting lists and share information on potential transplant recipients.

The challenge is this: how do we take these examples of collaboration and translate them into a broader framework? How do we set aside years of partisan politics and constant wrangling in favour of real and effective mechanisms that respect jurisdiction and responsibility but put the common good of the health system at the forefront? This challenge needs to be addressed, and soon, by both orders of government. Quite frankly, Canadians are tired of the finger pointing and "hollering from a distance" while both parties squabble over fundamental directions and funding. As part of their September 2000 agreement on health care financing, the federal and provincial-territorial governments agreed to a set of principles (see box below) that would guide future cooperation. As laudable as these principles are, it remains to be seen whether these principles actually provide a sound basis for intergovernmental cooperation.

First Ministers' Agreement of September 2000 on Health Reform in Canada

- Support the principles of universality, accessibility, comprehensiveness, portability, and public administration for insured hospital and medical services;
- Continue to renew health care services by working with other governments, communities, service providers, and Canadians;
- Promote those public services, programs, and policies which extend beyond care and treatment and which make a critical contribution to the health and wellness of Canadians;
- Further address key priorities for health care renewal and support innovations to meet the current and emerging needs of Canadians;
- Expand the sharing of information on best practices and thereby contribute to continuing improvements in the quality and efficiency of their health care services;
- Report regularly to Canadians on health status, health outcomes, and the performance of publicly funded health services, and the actions taken to improve these services;
- Work in collaboration with Aboriginal peoples, their organizations and governments, to improve their health and well-being.

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RESPONSIBILITY FOR ABORIGINAL HEALTH CARE

Another area that demands resolution is responsibility for Aboriginal health and health care programs. It is an area that has been surrounded by uncertainties that have had serious consequences to the health and health care of Aboriginal peoples.

As noted by the Royal Commission on Aboriginal Peoples, Aboriginal control of health and social services is essential to improve the quality and accessibility of health care for Aboriginal peoples and ensure that health programs meet their often very unique needs. In the last two decades, a process has been in place to gradually transfer control over delivering health services from the federal government to Aboriginal authorities. However, defining which Aboriginal peoples qualify for what federally funded health services or programs is complex. As a result, many Aboriginal peoples find themselves relying on provincial health programs that are designed to meet the health needs of the general population and may not reflect their specific needs.

Traditionally, Aboriginal peoples have emphasized a more integrated and comprehensive view of health than the current health care system has provided, with its narrower focus on hospital and doctor-delivered health services. In recent decades however, provincial and territorial governments have moved toward a more integrated approach that is perhaps more consistent with traditional Aboriginal perspectives on health. As a result, there has been some movement toward the integration of Aboriginal health services within provincial and territorial health care systems and the creation of Aboriginal-specific health programs. Aboriginal peoples and provincial and territorial governments, however, typically emphasize that greater Aboriginal control of health service delivery should not mean less responsibility by the federal government.

GLOBAL OPPORTUNITIES AND CONSTRAINTS

The world is becoming a smaller place indeed, and decisions made in one part of the world can and do have an impact on how we plan, organize, and deliver health services in Canada. We need to understand the challenges of globalization. We must protect our sovereignty and values but also seize the opportunities that globalization can bring.

On the one hand, some suggest that globalization potentially imposes some constraints on Canada's health care system. They argue that interpretations or disputes under international trade agreements such as the North American Free Trade Agreement could potentially impinge on our ability to protect public health services and set domestic policies. They argue that trade agreements may threaten our ability to recommend or implement reforms to the existing system. This is particularly true in

regard to potentially emerging areas of health coverage such as pharmacare or cases where private providers currently deliver certain health services. There also is a growing concern by some that multinational corporations and organizations such as the World Trade Organization are increasingly setting the agenda for health policy worldwide.

Globalization clearly constrains our ability to attract and retain qualified health care providers and professionals. Countries around the world, not just Canada, are facing severe shortages of some health care providers and international mobility makes it possible for these providers to move to wherever they want, provided they can meet the licensing requirements. At the same time, the mobility of providers from other countries raises fears that Canada will "poach" the best providers from underdeveloped countries.

At the same time, globalization offers tremendous potential for Canada not only to learn from other countries and take advantage of the newest treatments developed elsewhere, but also to export and market Canada's considerable expertise in the health sector. The global market for health products and services is estimated at more than $2 trillion annually and Canadian suppliers currently have just over a 2% share. Canadian expertise in a wide range of health fields could benefit significantly from increased global opportunities. Canadian research institutes, hospitals and universities, combined with highly skilled research and medical professionals, have an opportunity to play a significant role in breakthrough discoveries and to share their achievements with others around the world.

PROVIDER ORGANIZATIONS

While governments have sought various means to overcome the fragmentation of Canadian health care, providers have also made some progress in "knitting" the disparate pieces together. Yet it is a role that is largely unrecognized and most would agree that there is still more that could be done.

The education, regulation, and practices of health professionals are perhaps the strongest unifying force in health care in Canada today. Physicians, nurses, pharmacists, and many other providers have created strong national structures to standardize practices, disseminate best practice information, and introduce new innovations. Some have independent research capacities and readily contribute to national policy discussions.

As for the degree of collaboration *across* national organizations, current efforts could be expanded so that new policy ideas from national provider organizations better integrate the interests and thinking of a plurality of health professional groups. And despite the influence some national provider organizations have enjoyed on policy, there is no formal or ongoing liaison with governments. As a consequence, contact with governments is ad hoc and often focused on the crisis of the day rather than more long-term issues.

To improve collaboration across and among provider organizations, and between provider organizations and governments, some experts have suggested the creation of external advisory bodies. One of the more structured proposals is for a *Canadian Health Council* that would bring together the leadership of provider organizations with political leaders, leading health policy experts, patient advocates and citizen representatives. The Council would dialogue, deliberate and make recommendations to governments on major issues in health care.

Another option might be the creation of a *Canadian Quality Council*. This type of council would assess progress in improving quality in health care and make recommendations to government on steps needed to achieve better health outcomes. It would be composed of a small team drawn from providers, policy experts, the public and quality experts from other sectors, and would be seen by the broader public as independent and credible.

While these ideas have merit, it must be kept in mind that permanent advisory bodies have had a checkered history in Canada. While providing a stream of ongoing advice to governments, these advisory bodies can develop relationships that are too comfortable with the key players, with the result that their recommendations rarely challenge the status quo.

Initial Observations

Decisions about who leads our health system, how they make decisions, and what responsibilities they have are fundamentally important to the future of our health system. Today, we have a complex and confusing array of decision-makers involved, little clear direction and accountability, and more tension than collaboration among the key players involved.

On an initial basis, I suggest that:

- New and more collaborative governance approaches are needed. The existing system too frequently results in mounting tensions between provincial and federal governments with more focus on jurisdiction and authority and less on what is best for the future of the health system. The result is that too many Canadians have lost confidence that we have a clear direction for our health system and that appropriate decisions will be made.
- To put new relationships in place, governments may need to step back from their traditional perspectives, decide what is in the best interests of the health system overall, and develop new relationships and processes to achieve essential goals.

- While the issues surrounding responsibility for Aboriginal health are undeniably complex and involve an array of legal, treaty, and Constitutional interpretations, our collective inability to resolve them is putting the continuing health status of Aboriginal peoples in jeopardy.
- Globalization and trade liberalization present both opportunities and constraints. The opportunities for generating wealth are undeniable, but our ability to reform and innovate within the health system may be affected by the rules of international trade agreements.
- Canada has no shortage of provider groups and organizations, but greater collaboration among these groups is required. Moreover, direct linkages with governments should be put in place, focused on providing long-term input to shape Canada's health system rather than managing day-to-day crises.

Some Questions for Canadians

In thinking about new and more collaborative ways of leading and governing Canada's health system, I would like Canadians to think about these questions:

- *What is the right balance between national collaboration and standards, and provincial autonomy and experimentation?*
- *Are there better ways of sharing responsibility among the federal, provincial, and territorial governments and what are they?*
- *How do we ensure that we can maximize the opportunities and minimize the constraints inherent in international trade agreements and in an increasingly global economy?*
- *How do we ensure Aboriginal peoples can access quality health services that meet their unique needs?*
- *What role should provider organizations play in revitalizing Canadian health care today and in the future?*

CONSULTING WITH CANADIANS

The preceding chapters of this report serve an important purpose – to set the stage for a comprehensive dialogue with Canadians, to provide some preliminary ideas and observations, and to provoke your thoughts about where we go from here.

Early in my mandate, I made it clear that the recommendations my Commission would ultimately bring forward would be based on four things: the best available evidence, the advice of knowledgeable experts, the counsel of those responsible for the administration and delivery of health care, and most importantly the judgement of individual Canadians. I remain fully committed to this approach.

It is my strong view that the future of our health care system does not lie in finding some "magic solution." Rather, the future lies in how successfully the system is able to adapt to the changing values, needs and interests of Canadians. I do not believe it will be possible to make any substantial headway toward improving Canada's health care system, or to place it on a more sustainable footing for the future, without a workable consensus on how it must change. The issues are extraordinarily complex and extremely contentious, and agreement on even the most elementary facts seems elusive. Under these difficult circumstances, progress has proven extremely difficult, and civil discussion even more so. But I am convinced that Canadians are able and have the necessary will to confront the difficult choices that may be required.

In that context, I see three major challenges as we begin consultations with Canadians.

CHALLENGE ONE: UNDERSTANDING CANADIAN VALUES

I need to understand the values underpinning Canadians' perceptions of public health care. We know that most Canadians can articulate what elements of our current system they consider especially valuable. We also know that many are deeply troubled about specific issues such as crowded emergency rooms, long waiting lists for treatment, and shortages of health professionals. What is less clear is what Canadians are prepared to do or trade off to preserve or enhance what they like best about the system.

CHALLENGE TWO: PROMOTING BETTER UNDERSTANDING

The Commission must try to provide Canadians with a better understanding of the challenges confronting public health care, as well as choices and options available for addressing them. Prior to engaging Canadians in a national dialogue on the future of their health system, we will launch a brief but multi-faceted public education campaign to help frame the key issues and explore potential options.

CHALLENGE THREE: ENGAGING THE PUBLIC

I am committed to engaging Canadians in this debate and giving them a variety of opportunities to become involved and make meaningful and productive contributions to shape the future of public health care.

To meet those three challenges, our strategy seeks to:

- Enable Canadians to understand the issues and participate in the debate;
- Make the process relevant and accessible to individual Canadians;
- Actively engage stakeholder and expert groups in framing issues and defining realistic options;
- Acknowledge and reflect the results of other consultations underway or recently concluded across the country;
- Balance the need for a long-term vision based on the values of Canadians with practical solutions aimed at resolving urgent issues.

The strategy described in Appendix C will provide ample opportunity to engage Canadians in the kind of debate we so desperately need – to air the issues and ideas, see where the consensus lies, face the choices head on, and decide, together, what kind of health system we want for the future.

CONCLUDING COMMENTS

The past seven months have been invigorating and thought-provoking. My focus has been on learning as much as I can about the state of Canada's health care system. I have listened carefully to the ideas and opinions of countless Canadians from leading national experts to health ministers, heads of health regions, physicians and nurses on the frontlines of the system, and friends and fellow Canadians. I have struggled to come to grips with the underlying causes of many of the issues we face today and challenged myself and others engaged in this process to set aside our preconceived ideas and explore all the possibilities for the future.

Against that backdrop, we are now set to embark on a comprehensive consultation process. I am anxious to begin and anxious to hear the views of Canadians from coast to coast. I believe we must better weave the disparate elements of health prevention, promotion, and delivery into a more coherent and integrated system. As I have said, our job is to revitalize Medicare for the 21st century. Canadians today, and for generations to come, deserve nothing less.

APPENDICES

THE COMMISSION'S FACT-FINDING TO DATE

The work of the Commission is divided into two main phases, fact-finding between May and December of 2001, followed by a public consultation phase, beginning in January 2002. During the fact-finding phase, the Commissioner and Commission staff:

- Reviewed the rich body of literature on health and health care issues both here in Canada and abroad;
- Reviewed reports of previous provincial, federal and pan-Canadian inquiries into issues in the health care system;
- Established formal contacts with each of the premier's offices across the country for the purpose of regular information sharing;
- Formally met with or spoke to each of the provincial or territorial leaders;
- Formally communicated or met with numerous experts and stakeholder groups;
- Conducted site visits across the country.

This Appendix summarizes the work of the Commissioner and/or Commission staff during the fact-finding phase.

GOVERNMENT LIAISON

An important component of the Commission's work is ensuring that provincial and territorial governments are informed and included in the fact-finding and consultation process. The Commissioner has held teleconferences or meetings with every provincial and territorial leader. Other senior staff maintain ongoing relations with provincial and territorial liaison officers identified by the respective premier's offices.

SITE VISITS

During the fact-finding phase, the Commissioner visited a range of health care sites, from research and planning enterprises to primary care centres, high-tech tertiary delivery sites, and health sciences centres. These site visits assisted the Commission to

gain, first-hand, a flavour of the organization and delivery issues and challenges faced in a wide range of delivery sites.

Visits were made to the following sites (May to November 2001):

- South Riverdale Community Health Centre, Toronto, Ontario (May 8)
- Cardiac Care Network of Ontario, Toronto, Ontario (May 8)
- Group Health Centre, Sault Ste. Marie, Ontario (May 9)
- Evangeline Community Health Centre, Wellington, Prince Edward Island (June 5)
- Telemedicine Centre, Health Science Complex, Memorial University, St. John's, Newfoundland (June 6)
- GENOME Atlantic, Halifax, Nova Scotia (June 8)
- First Nations Health Program, Whitehorse, Yukon (July 12)
- Whitehorse General Hospital, Whitehorse, Yukon (July 12)
- Mid-Main Community Health Centre, Vancouver, British Columbia (July 13)
- CLSC Suzor Côté, Victoriaville, Quebec (August 14)
- Manitoba Centre for Health Policy and Evaluation, Winnipeg, Manitoba (September 17)
- University Health Network, Toronto Western Hospital, Toronto, Ontario (September 27)
- London Health Sciences Centre, London, Ontario (September 28)
- Cambie Surgical Centre, Vancouver, British Columbia (October 24)
- Hôpital Européen Georges Pompidou, Paris, France (November 28)
- Liljeholmens Community Clinic, Stockholm, Sweden (November 30)
- St. Göran's Hospital, Stockholm, Sweden (November 30)

STAKEHOLDERS

The Commission sought to hear from as many stakeholders – health-related consumer, provider, industry, labour, and advocacy groups – as possible during the fact-finding phase. In order to gain early insight into the range of issues and concerns that might exist across the stakeholder community, the Commission identified a broadly representative group of stakeholders from whom to solicit submissions. Stakeholder submission criteria and consultation approaches were refined based on early feedback from a small group with whom the Commissioner met in June 2001. A general call for input from stakeholders and the concerned public was made in September when the Commission's Web site was formally launched.

Between June 18 and 22, 2001, the Commissioner met with the following stakeholder groups:

- Association of Canadian Medical Colleges
- Canadian College of Health Service Executives
- Canadian Healthcare Association
- Canadian Home Care Association
- Canadian Medical Association
- Canadian Mental Health Association
- Canadian Nurses Association
- Canadian Palliative Care Association
- Canadian Pharmacists Association
- Canadian Public Health Association
- Coalition of National Voluntary Organizations
- College of Family Physicians of Canada
- Royal College of Physicians and Surgeons of Canada

Senior Commission staff has met with the following groups:

- BC Health Association
- Canadian Association of Optometrists
- Canadian Association of Psychologists
- Canadian Institute for Health Information

In addition, the Commissioner has formally addressed a number of stakeholder and other groups across the country and elsewhere, including:

- Canadian Federation of Nurses Unions (June 1, Edmonton, Alberta)
- Institute for Research on Public Policy (June 11, Montreal, Quebec)
- Canadian Medical Association (August 14, Québec, Quebec)
- Canadian Chamber of Commerce (September 17, Winnipeg, Manitoba)
- London Health Sciences Centre (September 28, London, Ontario)
- Ditchley Foundation (September 28, Cambridge, Ontario)
- National Association of Canadian Clubs (September 29, Saskatoon, Saskatchewan)
- Queen's University (October 12, Kingston, Ontario)
- Conference Board of Canada (October 18, Ottawa, Ontario)
- Carleton University (October 18, Ottawa, Ontario)
- Business Council on National Issues (October 19, Toronto, Ontario)
- Canadian Public Health Association (October 23, Saskatoon, Saskatchewan)
- College of Family Physicians of Canada (October 25, Vancouver, British Columbia)

- National Health Policy and Research Conference (November 5, Saskatoon, Saskatchewan)
- Conference of the Organisation for Economic Co-operation and Development (OECD) (November 6, Ottawa, Ontario)
- Faculty of Applied Health Sciences, University of Waterloo (November 20, Waterloo, Ontario)
- Frosst Health Care Foundation (November 21, Toronto, Ontario)
- Corpus Christi College, Oxford University (November 26, Oxford, UK)

Other Individual and Institutional Contacts

In addition to the fact-finding meetings and visits listed above, the Commissioner held meetings with a wide range of independent experts and distinguished Canadians. The following is a list of some of the individuals the Commissioner has met with, as of November 30, 2001. The list does not necessarily include people who participated in roundtable discussions and preparation of discussion papers.

- Julia Abelson, McMaster University (Hamilton, Ontario)
- Lucien Abenhaïm, Ministère délégué à la santé (Paris, France)
- Taylor Alexander, Canadian Association for Community Care Ottawa, Ontario)
- Keith Banting, Queen's University (Kingston, Ontario)
- Ruth Barrington, Health Research Board (Dublin, Ireland)
- Monique Bégin, University of Ottawa (Ottawa, Ontario)
- Louis Bélanger, Université Laval (Québec, Quebec)
- Howard Bergman, McGill University (Montreal, Quebec)
- Alan Bernstein, Canadian Institutes of Health Research (Ottawa, Ontario)
- Nick Black, London School of Hygiene & Tropical Medicine (London, UK)
- Alan Blakeney, former Premier of the Province of Saskatchewan (Saskatoon, Saskatchewan)
- Lucie Bonin, CLSC Suzor Côté (Victoriaville, Quebec)
- Paul Boothe, University of Alberta (Edmonton, Alberta)
- Virginia Bottomley, Member of Parliament (South West Surrey, UK)
- David Butler-Jones, Canadian Public Health Association (Ottawa, Ontario)
- David Cameron, University of Toronto (Toronto, Ontario)
- Canadian Blood Services (Ottawa, Ontario) (Gary Chatfield, Watson Gale, Graham Sher, Verna Skanes)
- Amit Chakma, University of Waterloo (Waterloo, Ontario)
- François Champagne, Université de Montréal (Montreal, Quebec)

- Eric Chevallier, Ministère délégué à la santé (Paris, France)
- Jakob Kjellberg Christensen, Danish Research Institute in Health Services (Copenhagen, Denmark)
- Michel Clair, Commission d'étude sur les services de santé et les services sociaux (Québec, Quebec)
- Carmen Connelly, Canadian Population Health Initiative (Ottawa, Ontario)
- André-Pierre Contandriopoulos, Université de Montréal (Montreal, Quebec)
- Agnès Couffinhal, CREDES (Paris, France)
- Thomas J. Courchene, Queen's University (Kingston, Ontario)
- Steve Davies, University of Wales (Cardiff, Wales)
- Michael B. Decter, Canadian Institute for Health Information (Ottawa, Ontario)
- Jean-Louis Denis, Université de Montréal (Montreal, Quebec)
- Steve Dewar, King's Fund (London, UK)
- Janet Dunbrack, The Frosst Health Care Foundation (Montreal, Quebec)
- Pierre J. Durand, Université Laval (Québec, Quebec)
- Janice Elliott, Public Policy Forum (Ottawa, Ontario)
- John Evans, University of Toronto (Toronto, Ontario)
- Robert G. Evans, University of British Columbia (Vancouver, British Columbia)
- Colin Feek, Ministry of Health (Wellington, New Zealand)
- Stefan Felder, University of Magdeburg (Magdeburg, Germany)
- Gary Filmon, Exchange Consulting Group (Winnipeg, Manitoba)
- Colleen Flood, University of Toronto (Toronto, Ontario)
- Michael Fox, The Foundation for Integrated Medicine (London, UK)
- John Frank, Canadian Institutes of Health Research (Ottawa, Ontario)
- Declan Gaffney, Greater London Authority (London, UK)
- Livio Garattini, Mario Negri Institute (Milan, Italy)
- Don Guy, Pollara Research (Ottawa, Ontario)
- Chris Ham, University of Birmingham (Birmingham, UK)
- Phil Hassen, Vancouver/Richmond Health Board (Vancouver, British Columbia)
- Al Hatton, The Coalition of National Voluntary Organizations (Ottawa, Ontario)
- Lord Hunt of Kingsheath OBE, Department of Health (London, UK)
- Jeremy Hurst, OECD (Paris, France)
- Naoki Ikegami, Keio University (Tokyo, Japan)
- Martha Jackman, University of Ottawa (Ottawa, Ontario)
- Stéphane Jacobzone, OECD (Paris, France)

- Marc Jegers, Université Libre de Bruxelles (Brussels, Belgium)
- Al Johnson, Former Senior Civil Servant (Ottawa, Ontario)
- Donald Johnston, OECD (Ottawa, Ontario)
- Tom Kent, Queen's University (Kingston, Ontario)
- Michael Kirby, Standing Senate Committee on Social Affairs, Science and Technology (Ottawa, Ontario)
- Bernard Kouchner, Ministère délégué à la santé (Paris, France)
- Arthur Kroeger, Carleton University (Ottawa, Ontario)
- Robert Lacroix, Université de Montréal (Montreal, Quebec)
- Paul A. Lamarche, Université de Montréal (Montreal, Quebec)
- Harvey Lazar, Queen's University (Kingston, Ontario)
- Pascale Lehoux, Université de Montréal (Montreal, Quebec)
- Kimmo Leppo, Ministry of Social Affairs and Health (Helsinki, Finland)
- Richard Lessard, Régie régionale de la santé et des services sociaux de Montréal-Centre (Montreal, Quebec)
- Emile Levy, Collège des économistes de la santé (Paris, France)
- Jonathan Lomas, Canadian Health Services Research Foundation (Ottawa, Ontario)
- Guillem López i Casasnovas, Universitat Pompeu Fabra (Barcelona, Spain)
- Judith Maxwell, Canadian Policy Research Networks (Ottawa, Ontario)
- Donald F. Mazankowski, Premier's Advisory Council on Health (Edmonton, Alberta)
- Michael Mendelson, Caledon Institute of Social Policy (Ottawa, Ontario)
- Lillian Morgenthau, Canadian Association of Retired Persons (Toronto, Ontario)
- Yves Morin, Standing Senate Committee on Social Affairs, Science and Technology (Ottawa, Ontario)
- Michaela Moritz, Osterreichisches Bundesinsitut für Gesundheitswesen (Wein-Stubenring, Austria)
- David Naylor, University of Toronto (Toronto, Ontario)
- Raymond Netzell, Liljeholmens Community Clinic (Stockholm, Sweden)
- Louis Omnès, Hôpital Européen Georges Pompidou (Paris, France)
- Stephen Page, Nestor Healthcare Group (Hatfield, UK)
- Pierre Paquette, MediResource (St. Lazare, Quebec)
- Karen Parent, Queen's University (Kingston, Ontario)
- Valérie Paris, CREDES (Paris, France)
- Ulf Persson, University of Lund (Lund, Sweden)
- Eduardo Gonzalez Pier, Secretaria de Salud (Colonia Juarez, Mexico)
- Andrew Podger, Department of Health and Aged Care (Canberra, Australia)

- Gérard de Pouvourville, Collège des économistes de la santé (Paris, France)
- Marie-Claude Prémont, McGill University (Montreal, Quebec)
- Carol Propper, University of Bristol (Bristol, UK)
- Noralou Roos, University of Manitoba (Winnipeg, Manitoba)
- Pär Axel Sahlberg, Ministry of Health and Social Affairs (Stockholm, Sweden)
- Mike Sharratt, University of Waterloo (Waterloo, Ontario)
- Duncan Sinclair, Health Services Restructuring Commission of Ontario (Kingston, Ontario)
- Kerstin Sjöberg, Federation of Swedish County Councils (Stockholm, Sweden)
- Mikael Sjöberg, Ministry of Health and Social Affairs (Stockholm, Sweden)
- Clive Smee, Department of Health (London, UK)
- Frank Sobey, Dalhousie Medical Research Foundation (Halifax, Nova Scotia)
- Simon Stevens, Prime Minister's Office (London, UK)
- Greg Stoddart, McMaster University (Hamilton, Ontario)
- Åke Strandberg, St. Göran's Hospital (Stockholm, Sweden)
- Jon Sussex, Office of Health Economics (London, UK)
- Arthur Sweetman, Queen's University (Kingston, Ontario)
- André Tourigny, Université Laval (Québec, Quebec)
- Carolyn Tuohy, University of Toronto (Toronto, Ontario)
- Philippe Ulmann, Collège des économistes de la santé (Paris, France)
- University Health Network Board of Trustees Members (Toronto, Ontario) (Carl Cardella, Amy Go, Laurie S. Hicks, Donald Lenz, John A. MacNaughton, Eileen A. Mercier, Philip S. Orsino, Bob Rae, Terrence J. Sullivan)
- Eddy van Doorslaer, Erasmus University (Rotterdam, Netherlands)
- Charles Webster, Oxford University (Oxford, UK)
- Michael Wilson, Canadian Council for Public-Private Partnerships (Toronto, Ontario)
- C. Ruth Wilson, Queen's University (Kingston, Ontario)
- Felicia Knaul Windish, Fundacio Mexicana para la Salud (Colonia Arenal Tepepan, Mexico)

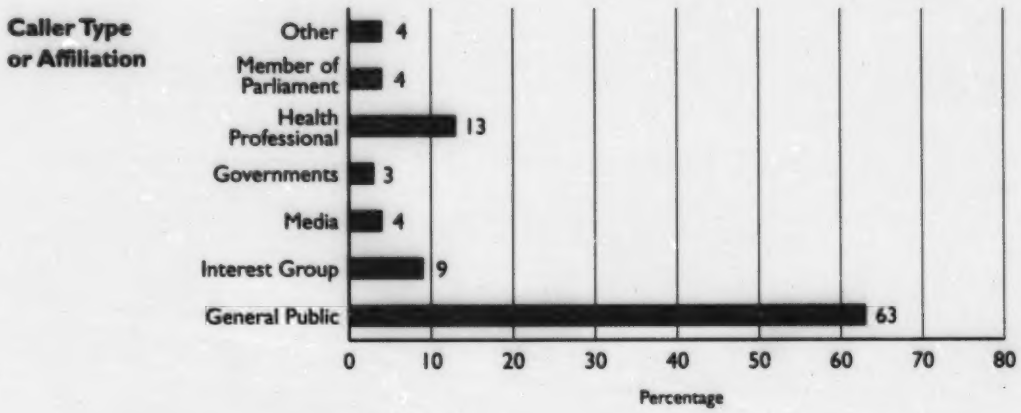
CANADIAN PUBLIC

The Commission wants to ensure that it hears from the Canadian public through as many means as possible. One of these ways is by e-mail through the Web site *www.healthcarecommission.ca*.

Early e-mails were from Canadians asking about the Commission's mandate and those looking for employment with the Commission. Most recently, respondents have been interested in knowing how to send submissions and participate in the public consultation phase.

Canadians have also been calling the Commission's 1-800 number. Of all the calls received between May and November 2001, 30% wanted to know how they could send comments to the Commission. Most of these calls were referred to the submission guidelines posted on the Commission's Web site. The following chart shows a breakdown by type of caller.

Finally, the Commission regularly receives and reads mail sent to its offices. From April to November, over 500 items were from citizens expressing concern or suggesting improvements to the health care system; 300 were briefs of various kinds.



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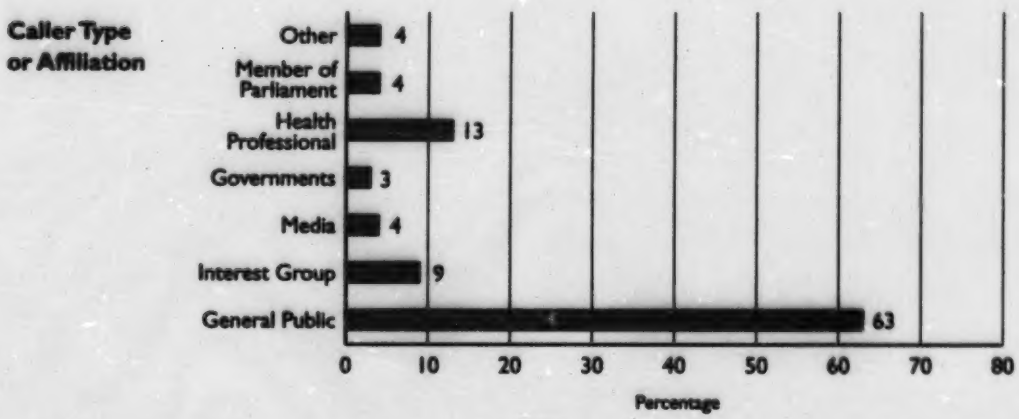

THE COMMISSION'S RESEARCH PROGRAM

The Commission's research work is being undertaken both by a small internal staff and through contracted work with policy analysts, some practitioners and scholars (most of whom are associated with think-tanks or universities) across the country.

The work of the Commission's small in-house research team is focused on synthesizing the existing body of knowledge about health care in Canada and the options that exist for strengthening the system. The purpose of this work is to ensure that the Commission does not expend resources trying to duplicate work that has already been done both in Canada and elsewhere.

COMPONENTS OF THE RESEARCH PROGRAM

Discussion Papers

Policy experts and scholars from across the country have been invited by the Commission to provide discussion papers that examine particular aspects of the four research themes noted in this report. In many cases, the Commission has asked multiple authors to examine the same particular question in an effort to ensure that the Commission receives a wide range of viewpoints. The box on the next page illustrates the kinds of questions and issues that the authors of the discussion papers have been asked to deal with.

1. Papers on Canadian Values:

- How Canadian democratic institutions affect our sense of ownership of the health care system;
- What values Canadians hold with respect to health care and how this compares with other Western democratic nations;
- How well the Canadian health care system includes marginalized groups;
- How Canadians could or should decide what is or is not covered by the health care system;
- How do we insure Canadians can be involved in decision making around health care policy;
- How should we decide how health care services should be delivered.

2. Papers on Sustainability:

- The options that exist for raising additional revenue for the health care system;
- The impact of the political environment on the sustainability of the system;
- The main cost-drivers within the system and how can they be controlled or contained.

3. Papers on Continuous Change:

- The political, economic, structural, legal, and social barriers to change within the system.

4 Papers on Cooperative Relations:

- The constitutional role of governments with regard to health policy and health care;
- The role of governments in priority setting for the system;
- The impact of intergovernmental relations on the sustainability and effectiveness of the health care system.

Research Projects

The Commission has also identified three areas of research for which it has developed more extensive research projects:

1. Health Human Resources;
2. The Impact of Globalization on Health Care in Canada;
3. Federal-Provincial Fiscal Relations.

Following three expert roundtables designed to provide advice on what the key research questions in these areas would be and where best to focus the need for original and innovative research, the Commission issued "requests for proposals"

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asking teams of researchers to design intensive research programs around these three themes and to answer some of the key research questions identified by the roundtable sessions.

After evaluating the proposals, the Commission awarded the three research contracts in December 2001. The work from these projects will be concluded by the summer of 2002, in time for it to be taken into account as the Commission prepares its final report.

Roundtables

The third element of the external research program consists of a series of roundtable sessions that bring together noted experts, policy analysts and academics for a day-long, in camera discussion focused on specific aspects of health policy.

The first three roundtables were convened to assist the Commission with the development of the research projects noted above:

1. *Health Human Resources* (held October 2, 2001, and hosted by the School of Nursing, Dalhousie University, Halifax, Nova Scotia)
2. *Globalization and Health Care* (held October 10, 2001, and hosted by l'Institut québécois des hautes études internationales at Laval University in Québec City)
3. *Fiscal Federalism and Health Care* (held October 13, 2001, and hosted by the Institute of Intergovernmental Relations at Queen's University in Kingston, Ontario).

Two additional roundtables will be convened in the Spring of 2002 with the aim of summarizing and synthesizing the various perspectives on particular issues:

1. *Financing Options* – focused on a discussion of the various options that have been proposed in the recent past for raising additional revenue through means other than direct taxation by government.
2. *Priority Setting* – focused on the role of governments in formulating and directing health policy and priority setting.

Three roundtables have also been held or are planned to take place internationally, in an effort to gain insight into the experiences of other countries with specific policy challenges similar to those facing Canadian health care:

1. *Reform in the National Health Service* – examined the recent changes in Britain's NHS and the lessons it may hold for Canada (hosted by The School of Hygiene & Tropical Medicine in London, England, on November 27, 2001).
2. *Co-payments and Related Charges* – examined the impact of various forms of direct-to-patient charges on the provision of health care in different European countries (hosted by the Collège des économistes de la santé in Paris, France, on November 29, 2001).

3. *The Impact of Cost Drivers on Health Care Systems* – an examination of the impact that such items as new technology and new pharmaceuticals have on the fiscal sustainability of the health system (to be held in the Spring of 2002).

Interviews

During both the domestic and international roundtables and at other opportunities that present themselves, the Commission's senior research staff will conduct in-depth interviews with policy experts and practitioners. The intent of the interviews is to probe the views of noted experts on specific questions that are relevant to the Commission's research agenda in those instances when the experts may be unable to provide their views to the Commission through other means. The senior staff expects to conduct upwards of 30 interviews over the course of the Commission's mandate.

Policy Forums

In an effort to ensure the public has an opportunity to see at least some of the research activities of the Commission (as distinct from the consultation work being done), the Commissioner plans to host a number of policy forums over the course of the mandate.

These forums will bring together a small number of noted experts to debate and discuss some of the health care issues that are most important to the Canadian public.

Dialogue with Citizens

The *Dialogue with Citizens* research project will identify and explore the values Canadians hold about their health care system. This innovative work will enable the Commission to assess how these values can be used to define and underpin a set of acceptable choices and trade-offs required to design the type of public health care system Canadians want for the future. The Canadian Policy Research Networks Inc., a not-for-profit public policy think-tank based in Ottawa, is leading the project.

As part of the project, 12 one-day dialogue sessions will be held across Canada involving approximately 40 randomly selected Canadians at each session. Participants will be provided with a set of four scenarios describing alternate organizing principles for Canada's health care system. They will then engage in a dialogue using the scenarios as the basis for defining a common "vision" for a future health care system.

A particular focus of the analysis will be to assess Canadians' openness to change and to better understand what trade-offs they are prepared to accept as they work toward a common vision (e.g., what type of care/services should be delivered by the public sector versus the private sector; what is the preferred means of financing health care; what is the proper balance between a consumer/patient's right to choice and the concept of universal, equal access to care, etc.). A national survey will be conducted to confirm the findings of the dialogue.

The information generated will inform the Commission's eventual recommendations for revitalizing Canada's health system. The dialogue sessions are part of the Commission's research activities and are not a substitute for broad public consultations.

The dialogue sessions will commence in January 2002 and will be completed by the early Spring. A report analyzing the results and significance of the dialogue will be prepared and posted on the Commission's Web site shortly thereafter.

Engaging Canadians in National Dialogue on the Future of Health Care

The Commission has opted for a four-phase approach for meeting its national dialogue objectives. The approach is based on:

- Supporting informed dialogue by providing interested participants with relevant and accessible information products and materials;
- Making the process relevant to individual Canadians and facilitating their participation in the process through partnerships with various third-party organizations and the media;
- Actively engaging stakeholder and expert groups in framing core issues and in defining realistic options;
- Acknowledging and reflecting the results of other recent and ongoing consultation processes and decisions taken by various levels of government;
- Balancing the imperative for providing a long-term "vision" or set of operating principles for the future of health care, with the imperative of addressing priority issues that require urgent attention.

The four phases are outlined below.

PHASE I (EDUCATION)

Public education and awareness efforts will be designed to support informed dialogue on the future of health care in Canada. While most of these activities will be concentrated in January and February 2002, public education efforts will be ongoing throughout the Commission's consultation activities. In addition to the release of this Interim Report, the education phase will involve the following:

1. Televised Policy Forums

The Commission will organize and record for future broadcast and video-streaming a series of policy forums on the following subjects:

- *Canadian Values*: What do Canadians want from their health care system?
- *Sustainability*: How to make health care sustainable?
- *Constructive Collaboration*: Who should do what in Canada's health system?
- *Continuous Improvement*: How can we make the system work?
- *Organizing Principles*: What is the role of the *Canada Health Act*?
- *Rural Health*: How should we define access?
- *Lessons from Abroad*: How have other countries responded to the challenge?

At the time of this report, the Commission is engaged in discussions with broadcasters regarding the timing, production and dissemination of these forums. Check the Commission's Web site (www.healthcarecommission.ca) for the time and dates of these broadcasts.

2. Release of the Commission's Workbook

In February 2002, the Commission will release a Workbook that identifies four different approaches (and their respective pros and cons) for making Canada's health care system sustainable. The Workbook is specifically designed to enable Canadians to identify what values and approaches they want their health care system to reflect in its policies and programs. The Workbook will be posted on the Commission's Web site where it can be completed online or downloaded for group discussion and mailed in. The Workbook may also be ordered via the Commission's toll-free number at 1-800-793-6161.

3. Web Postings

The Commission will post on its Web site all the formal submissions it has received over the course of its fact-finding stage, as well as any Commission-sponsored research, reports and discussion documents.

PHASE II (NATIONAL DIALOGUE)

This phase will consist of activities along *two distinct tracks* that will enable the Commission to issue recommendations that are both over-arching (e.g., the values and approaches Canadians expect their health system to reflect in its policies and programs) and issue-specific (e.g., how to reduce waiting lists, how to address shortages of health professionals, etc.). These activities will occur over March to June 2002.

At the time of this report, the Commission is still finalizing arrangements for the various components of its consultation efforts. The Commission Web site will provide a detailed calendar and schedule for the events and activities described below, including instructions on how to register for them.

1. Open Public Hearings (Day 1)

Open public hearings, chaired by the Commissioner, will be held in 17 communities across Canada. In early January, newspaper advertisements and the Commission Web site will invite those interested in appearing before the Commission to submit an abstract of their proposed presentation. (Groups or individuals that have already made formal submissions to the Commission will automatically be considered and are exempt from this requirement.) A template for the abstract will be posted on the Commission Web site concurrent with the advertising. The template will also be available by calling the Commission's toll-free number at 1-800-793-6161.

In selecting which groups or individuals appear, care will be taken to ensure the Commission hears as many different views/perspectives as possible. Groups or individuals not selected to appear will be invited to submit their views or positions in writing, and all inputs will be made part of the public record.

Each session will consist of:

a. An overview of relevant provincial/territorial health issues and/or presentations by provincial/territorial health officials.

b. Alternating presentations by:
   - Concerned individuals
   - Representatives from the health stakeholder, policy, research, and advocacy communities.

c. Presentations by Canadians in rural regions via teleconference (where possible).

d. Commentary and input on the day's activities from those attending the hearings.

2. Expert/Stakeholder Workshops (Day 2)

Closed workshops will be held in 9 of the 17 communities in which the Commission holds public hearings. These workshops will focus on reviewing and analyzing the results of the previous day's presentations and preliminary findings of the local *Dialogue with Citizens* Project (which involves up to 40 Canadians in each of 12 communities across Canada working through values-based choices on the future of health care). The goal will be to find areas of agreement and disagreement on key issues, and to discuss the implications of alternative policy directions.

Participants will be selected in advance from among those eligible to appear before the Commission during the Day 1 public hearings, and a summary report of the proceedings will be posted on the Commission Web site.

3. Partnered Policy Debates

To engage the expert stakeholder community in framing key health care issues and in exploring solutions to them, the Commission will partner with two or more health policy/advocacy groups. In selecting partners, care will be taken to ensure balance across regions, perspectives, and approaches.

The process will proceed in *three stages*:

In the **first stage**, the Commission partners will be tasked with developing a brief discussion document that frames a particular issue (see list of topics below), outlines two to three policy options and enumerates their "pros and cons."

In the **second stage,** partner organizations will host an open-to-the-public policy debate moderated by an eminent Canadian on the options presented in the discussion document. Concurrent with this debate, the discussion document will be posted for feedback on both the partner and Commission Web sites for a four-week period.

In the **third stage**, the event moderator will provide a summary report on the debate highlighting areas of consensus/disagreement. The report will be posted on the Commission Web site and will serve as a foundation for the Commission's eventual recommendations.

Partner organizations will address the following topics:

- *Waiting Lists/Timely Access to Care*: What should be done?
- *Health Human Resources*: How can we maintain and grow capacity?
- *The Canada Health Act*: Beacon or lightning rod?
- *Financing Health Care*: How to raise revenues?
- *Globalization*: Threat or opportunity?
- *Medically Necessary*: Who should decide what Medicare pays for?
- *Home Care*: Is a national strategy needed and affordable?
- *Pharmacare*: Is a national strategy needed and affordable?
- *Consumer Choice*: Can it exist within a public system?
- *Aboriginal Peoples' Health*: How can we do better?

The organizations participating in these activities and the delivery dates for the discussion documents and public forums will be announced in late January.

4. Consultation Workbook

As described earlier, the Commission will release a Workbook that identifies four different approaches (and their respective pros and cons) for making Canada's health care system sustainable. The Workbook will be posted on the Commission's Web site where it can be completed online or downloaded for group discussion and mailed in. The Workbook will also be distributed widely through a network involving some 50 health stakeholder groups that have agreed to support the Commission's outreach and dialogue activities. The Workbook may also be ordered via the Commission's toll-free number at 1-800-793-6161.

PHASE III (ANALYSIS/SYNTHESIS)

A series of five closed, facilitated regional roundtable sessions will be held. Up to 20 participants for each session will be chosen from among the groups and individuals who participated in the Phase II activities. The objectives of these sessions will be to synthesize Phase I and II outputs and results on a regional basis. Public and patient/consumer representatives will be invited to participate in the discussion and a report summarizing the results of each session will be made public. These sessions will occur in June and July 2002, and will be a precursor to the national multi-stakeholder conference in the Fall of 2002.

PHASE IV (VALIDATION)

A national multi-stakeholder conference will be held on the theme: *Building a Health Care System for the 21st Century*. The national conference will provide an opportunity to discuss the results of the preceding consultation phases, to present the Commission's research findings, to review proposed policy directions, and to assess their implications. The goal will be to move toward consensus on a coherent set of recommendations for placing the health care system on a more sustainable footing for the future.

A broad-based Conference Steering Committee will be established by the Commission to assist in the selection of participants and advise on the conference format/approach.

CONCLUSION

It is the Commission's hope that the range of consultation and engagement activities outlined above will provide ample opportunities for both individual citizens and stakeholders to interact with the Commission. Hearing from the public and engaging in an informed and reasoned discussion that weighs the options before us is the most important step in our collective journey toward a solution that reflects our aspirations.